OFFICE OF THE CORRECTIONS OMBUDS

Monthly Outcome Report
March 2022

The Office of the Corrections Ombuds (OCO) investigates complaints regarding any Department of Corrections' (DOC) actions or inactions that adversely affect the health, safety, welfare, and rights of incarcerated individuals. RCW 43.06C.040. RCW 43.06C.040(2)(k) directs the ombuds to render a public decision on the merits of each complaint at the conclusion an investigation. All cases opened by the OCO are considered investigations for the purposes of the statute. As of March 15, 2022, the OCO opens a case for every complaint received by this office. The following pages serve as the public decisions required by RCW 43.06C.040(2)(k).

Case Closure Reason	Meaning	Total
Assistance Provided	The OCO achieved full or partial resolution of the person's complaint.	50
Information Provided	The OCO provided self-advocacy information.	33
DOC Resolved	DOC staff resolved the concern prior to OCO action.	53
Administrative Remedies Not Pursued	The incarcerated person did not yet pursue internal resolution per RCW 43.06C.040(2)(b).	28
Substantiated Without Resolution	The OCO verified the concern but was unable to achieve a resolution to the concern.	16
Insufficient Evidence to Substantiate	Insufficient evidence existed to substantiate the concern.	24
No Violation of Policy	The OCO determined that DOC policy was not violated.	63
Unexpected Fatality Review	The incarcerated person died unexpectedly, and the death is under review.	2
Person Left DOC Custody	The incarcerated person left DOC custody prior to OCO action.	8
Person Declined OCO Involvement	The person did not want the OCO to pursue the concern or the OCO received no response to requests for more information.	3
Lacked Jurisdiction	The complaint did not meet OCO's jurisdictional requirements (typically when complaint is not about an incarcerated person or not about a DOC action).	6
Declined	The OCO declined to investigate because the complaint had already been investigated by this office.	1

All published monthly outcome reports are available at https://oco.wa.gov/reports-publications/reports/monthly-outcome-reports.

Monthly Outcome Report: March 2022

	Institution of Incident	Complaint Summary	Outcome Summary	Case Closure Reason
	Airway Heights Corrections Center			
1.		Individual states DOC is refusing to let him use the attorney phones for confidential phone calls. States the sergeant said that they can use their 20 minutes that they get a day to call their attorney or Ombuds.	Individual did not grieve the concern. Per RCW 43.06C(2)(b), the OCO requires the individual reasonably attempt to resolve the concern through the DOC internal grievance process.	Administrative Remedies Not Pursued
2.		Person reports he needs surgery but was denied based on his release date. He also reports that he is housed in an upper bunk despite his injury making the ladder difficult to climb.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
3.		Person is concerned that DOC is violating policy by not providing bathroom privacy or dressing/undressing privacy where cisgender and transgender persons are housed in a cell together.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
4.		Person reports oranges believed to be for consumption by the incarcerated population were being thrown by DOC staff members in a distance throwing competition. At time of the call oranges remained strewn about the breezeway.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
5.		Person reports they had been approved for marriage at AHCC, but when person was on GRE, they were denied the process to be married.	The OCO provided assistance. This office provided to DOC evidence of their marriage approval from a previous facility. As they had previously been approved for marriage, permission to get married was granted.	Assistance Provided
6.		The patient reports requesting a complex hernia repair several times but was denied by DOC medical. He says that he has advanced liver	The OCO provided assistance. This office alerted the Facility Medical Director and substantiated that the DOC Care Review Committee (CRC)	Assistance Provided

	disease, and his life expectancy may be shortened with the use of anesthesia. However, says the procedure is necessary to improve his quality of life due to the significant impact on his activities of daily living (ADLs). The patient requested to see a liver specialist, surgeon, and anesthesiologist for consult outside of DOC and to create a treatment plan.	had denied hernia surgeries in previous years. Due to changes in symptoms and DOC policies regarding hernia repairs, DOC agreed to refer the patient to a surgeon for consult, noting general appointment delays due to COVID. If surgeon agrees hernia surgery is medically indicated and safe considering coexisting conditions, the specialist referral would then be placed.	
7.	The parents of the incarcerated individual received a phone call from a facility staff member telling them that their son was found unresponsive in his cell. The mother later received a call from a hospital staff reporting that son was receiving medical care at the hospital. The mother was told to call back in 24 hours to receive an update. She tried to call both the hospital and AHCC and was not successful in reaching someone who could assist.	The OCO provided assistance. This office provided the individual's mother additional contact information for DOC staff who she could contact for further information. The OCO also contacted facility leadership to request that AHCC Heath Services contact the mother; staff reported that they would contact her.	Assistance Provided
8.	The patient was previously approved twice for necessary treatment but decided to opt out due to personal issues that she wanted to focus on first. She has decided she is now ready to start the treatment; however, she reports that the facility will not approve the prescription. When she tries kiting, asking for appointments, and grieving, she is told there is an appeal process for Care Review Committee decisions. She has also been told she has to go through mental health before she can access the treatment.	The OCO provided assistance. This office alerted DOC health services and contacted headquarters staff to request resolution. The DOC agreed to schedule a consult with a transgender care specialist and the patient was again approved for treatment.	Assistance Provided
9.	The complainant reports the patient has been out of his medication since mid-January. He has tried to work with Health Services to rectify the situation, but he remains without his medication for high blood pressure, pain, and reflux.	The OCO provided assistance. This office alerted the Health Services Manager and confirmed that a keep on person (KOP) prescription refill would be provided that day.	Assistance Provided
10.	Person is requesting proof that mother's advance pay phone account has been refunded. He has power of attorney for his mother.	The OCO was able to provide assistance by confirming that this person's mother received her refund. The OCO also confirmed that this person received a copy of the refund receipt.	Assistance Provided
11.	Incarcerated individual filed five resolution requests in one week	The OCO provided assistance. This office alerted DOC staff of this concern	Assistance Provided

	related to staff misconduct. It has been over six months and the individual has not received a response from the resolution department on three of the five resolution requests.	and was then able to confirm that the resolutions team at AHCC had responded or was in the process of responding to the resolution requests per policy.	
12.	The patient reports that he has submitted three grievances related to medication prescriptions and has not received responses from any of them.	The OCO provided assistance. This office alerted the Health Service Manager of the concern and confirmed medical grievance had been reviewed and now at level II.	Assistance Provided
13.	Family reports that individual gets insulin twice per day. However, due to lack of medical staff response, DOC staff did not provide insulin until the afternoon. The patient's blood sugar was very high after not receiving his regular morning insulin and he filed an emergency grievance. DOC medical admitted they failed to deliver his insulin that he was supposed to get in the morning. Family is concerned individual could suffer severe long-term problems when he does not receive his proper insulin doses.	The OCO reviewed the DOC's initial grievance response and determined patient had been seen by provider and the issue had been addressed.	DOC Resolved
14.	Incarcerated individual reports he was sent back to his unit from attempting to pick up medications by custody. Individual was sent back for arriving late, despite physical condition making it difficult to ambulate quickly.	The OCO reported this concern to DOC staff and was informed that staff are aware of the situation and have taken actions to prevent this from occurring in the future.	DOC Resolved
15.	Person is experiencing increased severe pain in relation to chronic condition. Pain is causing difficulty in performing daily activities.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted the DOC and were informed the patient has seen both a medical provider and an outside specialist since time of complaint and has an active pain management plan.	DOC Resolved
16.	The patient reports kiting and talking with his provider for years about ongoing issues with numbness in his feet and has been denied a second opinion and medical boots. The patient requested an MRI and to determine the cause of the numbness as well as treatment options.	The OCO alerted DOC Health Service Manager and Facility Medical Director and confirmed recent appointments and evaluation leading to diagnosis of neuropathy. The OCO confirmed additional studies pending (MRI, labs, and podiatry referral) and FMD noted follow up regarding medical footwear referral considering recent diagnosis.	DOC Resolved
17.	The patient states his current provider has been unprofessional and accusatory regarding requests	The OCO alerted DOC health services staff. Providers are assigned based on last name and not reassigned unless	Information Provided

	for treatment for a chronic illness. Individual cited a 2021 medical emergency incident in which he was accused of seeking narcotics when asking for help during a flair up. He says he has gastrointestinal disease which requires ongoing care, specialists, and follow ups, which he feels he is not receiving.	determined by the Facility Medical Director. The OCO shared options to contact FMD and to send kite prior to scheduled medical visits to request that a third party manager sit in during appointment.	
18.	The patient received six visits with physical therapy post-injury with hardware placement and does not feel that was a sufficient amount.	The OCO alerted DOC health services. This office also provided information about requesting additional sessions and staff points of contact.	Information Provided
19.	Incarcerated individual wonders when people will receive new mattresses as outlined in the OCO Systemic Issue Report on DOC mattresses.	The OCO provided detailed information about how his current facility is distributing new mattresses and provided information about how to ensure the individual gets access to their new mattress.	Information Provided
20.	Family reports concerns about patient's treatment for Crohn's disease.	The OCO contacted the complainant multiple times and received no follow up response. No grievance on file or direct consent from patient for OCO investigation. The OCO sent patient a letter with information on how to file a grievance and follow up with our office if he is having ongoing concerns and can provide details.	Information Provided
21.	Incarcerated individual is continually denied access to the law library. They have been told to watch call out and have not been placed on it. The individual reports that the denial of law library access is retaliation.	The OCO confirmed that this individual is currently receiving as much access to the law library as AHCC can provide while also allowing others to have access when the facility is not on outbreak status. The OCO provided information regarding the DOC policy explaining how to apply for priority law library access by reviewing DOC 590.500 Legal Access for Incarcerated Individuals section D, which addresses the priority access process. Currently the AHCC Law Library is providing items upon request, including case law, e-filing, notary, forms, legal copies, and legal mail. This office explained that individuals may kite the Law Librarian to access these services while the facility is on outbreak status.	Information Provided
22.	The individual has not been able to work at their job in commissary because of the COVID quarantine cohort schedule.	The OCO informed this person that this office is not opening investigations for individual cases in relation to DOC policies 410.030, 410.430, 410.050, 670.000 and RCW 43.06.220 in its	Information Provided

		handling of COVID-19 concerns. However, OCO has been actively monitoring DOC's response to COVID-19, including preventative actions. This office has been gathering COVID-related information from incarcerated individuals and will make additional recommendations to DOC for further improvements where needed and as appropriate.	
23.	The patient reports concerns about post-surgery follow up care during a 2020 procedure and mentioned policy change related to post-surgery pain medication access.	The OCO was unable to identify a current medical issue or healthcare resolution previously filed which relates to this concern. The OCO reviewed policy, available documentation, provided information for submitting current medical complaints, and documented 2020 incident and feedback on policy change in database.	Information Provided
24.	Incarcerated individual reports that DOC is not allowing him to transfer to work release even though he is at the final stage of chemical dependency programming. The individual reports that lack of programming staff has halted most classes. The individual feels penalized because of a lack of staff to finalize programming requirements is harming individual's plans for lesser confinement.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The incarcerated individual was held at AHCC due to the DOC determination that this individual was not in compliance with their current behavior plan. The individual is set to transfer to work release soon.	No Violation of Policy
25.	The patient reports treatment concerns for an injury that was exacerbated by a recent accident at work.	The OCO alerted the facility healthcare team, confirmed diagnosis, initial treatment plan, and follow up appointment with specialist. Treatment is ongoing, facility is awaiting neurosurgeon's notes to determine next steps.	No Violation of Policy
26.	Incarcerated individual was terminated from Correctional Industries (CI) position in laundry on suspicion of stealing food. The individual reports he wasn't involved and the individual who did it admitted to stealing the food. While the individual was not punished for the stealing allegations, CI did terminate him. He does not understand why and would like his job back.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Although DOC did not have enough evidence to infract this Individual, CI had enough evidence to terminate them from their position. Per DOC 700.000 Work Programs in Prison, "Assignment to a work program may be suspended/terminated based on security/disruption concerns resulting from, but not limited to, an alleged violation or pending investigation." This means that even though DOC did not have enough evidence to infract	No Violation of Policy

		this person, CI can still make the decision to terminate based on their own judgement of the situation.	
27.	Family ordered two Bibles for incarcerated individual but only one was delivered by the chaplain. The missing Bible in question was delivered to AHCC. Grievance has been submitted and incarcerated individual is awaiting DOC response.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Mail in question was not addressed properly. According to DOC 450.100, mail must be properly addressed with the individual's name and DOC number. The OCO contacted DOC staff who reported package had been incorrectly addressed.	No Violation of Policy
28.	Incarcerated individual reports while he was on community custody and using intoxicants his Community Corrections Officer (CCO) had him sign to confirm a DOC-imposed no contact order between his wife and himself. Now that he is in prison, the no contact order is creating a barrier for him communicating with his children and wife.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC is acting within policy by deciding to uphold the no contact order. DOC-imposed no contact orders are governed by DOC 390.600 Imposed Conditions, which does allow DOC staff to impose conditions per section I.A.	No Violation of Policy
29.	Incarcerated individual reports safety concerns at the facility he be transferred to. He does not want to transfer there.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reported the safety concerns to DOC staff; DOC responded that because there is no specific threat that can be named by this person, DOC does not have evidence to confirm a safety concern. The OCO provided this person with self-advocacy resources.	No Violation of Policy
30.	Incarcerated individual is wondering if DOC staff are legally allowed to take photos of his tattoos for law enforcement.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Law enforcement has a right to request updated photos of a person's tattoos for a crime they are investigating, and DOC has a duty to perform requests related to law enforcement investigations.	No Violation of Policy
Bellingham - Whatcom County			
31.	Person tested positive for COVID-19 and was not given a copy of the test or tested per protocol a second time before being sent to another facility to quarantine.	The OCO provided assistance. This office contacted the facility to ask that staff provide the person with their test result, which staff agreed to do.	Assistance Provided
Bishop Lewis - King County			
32.	Person was at a work release and after a few days was sent back to DOC custody.	The OCO lacks jurisdiction to investigate this complaint because the complaint relates to an action taken by	Lacked Jurisdiction

		an agency other than the Washington State Department of Corrections. This person has been sent to county jail due to previous case. This case is being monitored by DOC work release supervisor; as soon as they have authority they will send him back to DOC work release.	
	Cedar Creek Corrections Center		
33.	Person states he applied for graduated reentry (GRE) and was denied. Person has domestic violence concerns but is trying to release on GRE in other counties.	Person was released to a nearby county that did not have a victim concern.	DOC Resolved
34.	Patient's surgery was delayed due to COVID outbreak at facility. He believes he should have been able to go out to surgery because he had several negative COVID tests during the outbreak.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted health services management who confirmed that patient is currently scheduled for surgery consult with an outside provider.	DOC Resolved
35.	Person says that they applied for GRE and when it came time to submit the address their counselor refused to process the address submitted.	Person does not qualify for GRE due to their prior conviction and lack of associated treatment.	No Violation of Policy
	Clallam Bay Corrections Center		
36.	Individual's CPAP machine was recalled by the manufacturer. The individual has been without a machine for three months.	The OCO provided information to the individual and confirmed that the DOC has ordered a replacement CPAP machine.	Assistance Provided
37.	A family member of an incarcerated person is requesting a status update for her loved ones graduated re-entry application.	The OCO provided self-advocacy information to the family member. The OCO shared how to access the DOC's extensive information online and how to contact DOC re-entry services staff.	Information Provided
38.	Family member of an incarcerated individual reports they are concerned about their loved one being placed on quarantine and the way DOC is responding to the COVID-19 outbreak.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. When an individual is exposed to COVID-19, DOC places them on quarantine to mitigate COVID-19 spread in the facility.	No Violation of Policy
39.	Individual was infracted and found guilty after an extended investigation for conspiring to import illicit materials to the facility. As a part of that investigation, other (unrelated) behavior was uncovered, for which was also infracted. This information was included in the investigation packet for the original infraction, which was ultimately used in	The OCO was unable to identify evidence to substantiate a violation of policy. OCO reviewed the disciplinary information and hearing audio. A review of the hearing audio showed that the hearing officer expressed doubt that a requested witness statement would be able to overcome the other documentary evidence that DOC provided. Nevertheless, the	No Violation of Policy

	infracting another individual for the conspiracy charge. Individual believed the hearing officer purposely disallowed witnesses and made a guilty finding before all the evidence was heard. Further, the individual reported that the evidence regarding the unrelated behavior which was included in the investigation packet was shared with the other infracted individual during his hearing, which the caller believed put him in danger.	hearing was continued to seek that witness statement. According to WAC 137-28-285(1)(f), hearing officers have discretion to include or exclude witnesses if deemed irrelevant, duplicative, or unnecessary. The hearing officer did not violate this policy in using his discretion to assess the usefulness of requested witness statements. As to the concern about information being used in another individual's hearing, OCO agreed that the investigatory practices that led to this information being shared with another individual were concerning. For that reason, OCO staff alerted facility administration of this situation. Facility leadership reviewed the concern and worked to clarify privacy expectations and investigatory practices with hearing staff. No specific policy currently exists to govern this issue, so no policy was technically violated.	
40.	The incarcerated person wants to release from the intensive management unit (IMU). DOC staff report to him that he has not released yet due to safety concerns between him and another incarcerated person. The individual does not believe the DOC staff and would like the OCO to investigate.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per policy 420.140(11)(13), "Housing assignments will be based on available information, including threats to safety." The OCO confirmed that the individual does have safety concerns related to another incarcerated individual. The DOC has created a plan to have them transferred out of IMU as soon as the other individual is removed from the facility.	No Violation of Policy
Coyote Ridge Corrections Center			
41.	Person believes he is not being seen by medical as result of staff actions.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
42.	Patient had received HSR for thermals and was on the callout for picking up thermals but was not given the clothes. He refused insulin shot and filed medical emergency and was told by staff that medical	The incarcerated person has not pursued internal resolution for both concerns. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it	Administrative Remedies Not Pursued

	provider determined it was not an emergency.	through the DOC internal grievance process, administrative, or appellate process.	
43.	Incarcerated individual received a new mattress and was later moved to a different cell due to COVID. They have medical problems and would like a new mattress when they receive the new cell assignment. DOC staff have not yet addressed request.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
44.	Individual reports that he is being targeted by DOC staff due to a hearing impairment and staff are not sharing the callout times over the loudspeaker nor recognizing his hearing impairment. Person relayed additional concerns about a behavioral observation entry (BOE).	The incarcerated individual did not grieve the video visit concerns prior to filing a complaint with the OCO. Per RCW 43.06C.040(2)(b) the incarcerated individual must pursue internal resolution before the OCO is able to investigate the case. The grievance for the behavioral observation entry (BOE) did not yet receive a level 2 response. The OCO advised the incarcerated individual to pursue the level 2 response. The OCO also advised the individual to make an appointment with health services so that the hearing impairment can be documented.	Administrative Remedies Not Pursued
45.	The patient reports missing orthotics. Patient also requested that the OCO look into his treatment for water retention.	The OCO provided assistance. This office alerted DOC medical and was able to confirm a recent appointment and that there is a treatment plan in place. OCO's review also confirmed that medical met with the patient at his cell front and scheduled an additional appointment with a provider to address the orthotics issue. The patient later confirmed that the concern about the medication for water retention had been addressed by DOC. OCO staff also verified that the grievance team is working to get new compression stockings as they are clinically indicated.	Assistance Provided
46.	The person reports he ordered glasses from Correctional Industries several months ago and has not received his glasses.	The OCO provided assistance. This office alerted health services, and DOC agreed to schedule the patient with optometrist due to the original product no longer being available. A new order will be submitted following appointment.	Assistance Provided
47.	The patient reports diagnosis of dead hip bone with leg and hip pain for over a year. DOC medical was giving	The OCO provided assistance. The OCO alerted DOC medical of this concern. This office confirmed that the patient	Assistance Provided

	him steroid shots to ease the pain. The individual has started working again and is feeling pain. He is waiting for another steroid shot because it has been over six months, and he has been told via kite that he is on the schedule but has not seen his name on the call outs. He also reports that he is supposed to receive an MRI but has not received the Care Review Committee (CRC) decision document or appeal form from DOC.	had been scheduled for the injection. The OCO requested that DOC provide CRC decision documents to patient. OCO review showed that this case was not reviewed by CRC but instead was handled as a level III resolution request and which had found that MRI was not medically indicated. OCO staff discussed investigation outcome updates and provided self-advocacy information for medical follow up.	
48.	The patient was transferred before glasses were prescribed to him. It has been more than 60 days and he has kited medical and the optometrist multiple times and has not received a response.	The OCO provided assistance. The OCO alerted DOC health services of the concern and substantiated that DOC was unable to locate previously ordered glasses. As a result, DOC ultimately scheduled patient for a follow-up to order new glasses.	Assistance Provided
49.	Family called to report individual is in segregation and is not receiving proper medical treatment. Caller reports individual is diabetic and must have his insulin close to the time he eats. However, DOC staff do not bring insulin to him until three hours after breakfast. Family member stated that individual did not know how to request help.	The OCO provided assistance. This office alerted the DOC Health Service Manager and substantiated issues with meal and insulin delivery due to COVID outbreak staffing and porter impacts. The DOC later added snack carts for insulin patients. The OCO confirmed that a follow up appointment is scheduled with health services so that patient has the opportunity to discuss any new issues.	Assistance Provided
50.	Incarcerated individual reports that a classification review for his risk level assessment resulted in him being assessed as “low risk” to “moderate” but he does not understand why. He heard that it may be due to limited visits and is not getting clarification on the reason for the change.	The OCO provided assistance. This office contacted DOC to gain clarification of why the risk level changed. DOC stated that when a question comes to the Case Management Services regarding the Contact Risk Level or an assessment, they complete a review of the assessment to ensure consistency. Because the OCO asked about the current level, a secondary review was completed. As a result of this secondary review, DOC changed the risk level back to low.	Assistance Provided
51.	The patient reports requesting hormone replacement therapy (HRT) and alternative clothing items for several months. Patient was able to get blood drawn but has had no further responses to resolution requests and has not received a prescription.	The OCO’s review determined that the patient had been approved for the prescription and follow up labs prior to OCO outreach. Patient was notified of latest lab results, had medication adjusted based on results, and will receive follow up labs/continued monitoring.	DOC Resolved

52.	The patient reports having ongoing issues accessing care for his chronic pain. Over time his knee has gotten worse and he has not had access to a possible surgery that was previously considered. He sent a kite to medical requesting to be seen about the worsening pain. He was given a cortisone shot and told that it will last several months, but the pain returned. Patient says the Care Review Committee is reviewing case for specialist.	The OCO alerted facility Health Service Manager, and confirmed patient was scheduled for specialist, and an additional specialist follow up appointment is pending.	DOC Resolved
53.	Person says that they are only 60 days to their earned release date, but DOC is now saying they must serve time for sanctions on another case which is adding more time they must serve.	OCO reached out to the facility about the time calculation, the reason for the additional 60 days is due to a community custody sanction which OCO is unable to investigate as there is no jurisdiction over community custody concerns. OCO confirmed that the reason for the extended release date and advised the incarcerated individual they would need to reach out to community custody about the sanctions.	Information Provided
54.	Incarcerated individual received an infraction and had questions concerning extended family visits (EFVs) and whether infractions impacted their access to EFV for one or three years.	The OCO provided information to the incarcerated individual regarding DOC's family visitation policy.	Information Provided
55.	Complainant states that during the COVID outbreak in the beginning of February, DOC moved people into quarantine and instead of the cell doors getting dead locked, they had other incarcerated individuals pack out the cells. He states he filed a grievance and never received a response. Also. he appealed his classification and still has not heard a response.	The OCO provided information on the delay. The OCO confirmed with the facility that they do have his grievance but are behind on responding. His classification appeal was recently entered into the computer so the individual should be receiving the response soon. The OCO advised the individual of this information.	Information Provided
56.	In November of 2020, an incarcerated individual died after a reported altercation with another named incarcerated person. Concern is that this is a homicide and the request is for an independent review of the incident.	This incident occurred before the Unexpected Fatality Review (UFR) process was established. The OCO independently reviewed records related to this incident, including incident reports and infraction reports, discussed the investigation on multiple occasions with DOC facility and headquarters leadership, and reviewed the OCO's review outcome with the County Prosecuting Attorney before closing this case, in order to not	Insufficient Evidence to Substantiate

		interfere with potential criminal charges. Based on this independent review of this incident, the OCO is unable to find there is evidence to substantiate the complaint that a specific person is responsible for the death of the deceased incarcerated individual.	
57.	Individual states his daughter has been denied extended family visits (EFVs) by DOC headquarters. He reports that the reason for denial is due to the conviction type. In the denial it does not seem that they have reconsidered the fact that he has programmed a lot and has good standing.	The OCO was unable to substantiate a violation of DOC policy. The OCO reviewed the extended family visit (EFV) denial and found no violation of DOC 590.100 as the denial was due to the likeness of the visitor to the incarcerated individual's victim. The OCO advised the incarcerated individual that this denial is within DOC policy.	No Violation of Policy
58.	The patient reports he is not being treated for an injury and has not received follow up since x-rays were taken.	The OCO alerted DOC medical and confirmed that he has a treatment plan in place. Records indicate patient has had multiple follow-up appointments since the x-ray. DOC staff agreed to schedule a follow up with the provider to evaluate healing and next steps.	No Violation of Policy
59.	Individual reports he received an infraction for not wearing his mask while he was still chewing a banana.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC lowered the infraction to a general infraction for failure to follow orders, rules or policies. This infraction was lowered from a serious to a general infraction, and as OCO only investigates serious infractions, further investigation was not done.	No Violation of Policy
60.	Incarcerated individual states that they believe their time calculation is wrong.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO contacted DOC regarding the time calculation. RCW 9.94A.729 gives DOC the authority to adjust credit certified but not the authority to change days certified by the jail as lost or not earned. Because the person was not serving time solely on the jail cause, they were not given credit for time served based on RCW 9.94A.505. The OCO advised the individual of this information.	No Violation of Policy
61.	Complainant states the incarcerated individual was not given a DOSA revoke hearing. The treatment program lasted twice as long due to	The OCO sent a confidentiality waiver to the incarcerated individual and ombuds request form to investigate this concern. This office did not receive	Person Declined OCO Involvement

	COVID. The incarcerated individual was harassed during his promotion meeting and is not able to work or get rehab programming,	any response from the incarcerated individual.	
62.	Family member believes incarcerated individual's due process rights were violated because anyone with cognitive, behavioral, or mental health issues automatically qualify for an interpreter/ counsel which he was denied. Family member expressed a double jeopardy concern as this person had already been sanctioned for the serious and minor infractions that eventually were the resulting behaviors that led to the core of his DOSA revoke.	The OCO sent a confidentiality waiver to the incarcerated individual and ombuds request form to investigate this concern. This office did not receive any response from the incarcerated individual.	Person Declined OCO Involvement
63.	Person received a major infraction for an incident they say did not occur.	This person was released from DOC custody prior to the OCO taking action on their complaint. Person was provided a pathway for reentry.	Person Left DOC Custody Prior to OCO Action
64.	Complainant states their grievances are being delayed as well as mail and other things. They want DOC to comply with policy regardless of COVID.	The OCO investigated the six most recent grievances the individual had filed. There was a five-to-eight-day delay in responding to three of the grievances. Due to COVID there are numerous delays throughout DOC. The OCO substantiated the concern and sees the grievances have been delayed but are unable to resolve the concern.	Substantiated Without Resolution
65.	Individual expressed concerns about being denied access to alcohol treatment.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The incarcerated individual will be released in a few months, so he may not have time to receive the treatment at the facility. However, he would then receive it while on community custody. The OCO advised the incarcerated individual of this information.	Substantiated Without Resolution
66.	Complainant states they were supposed to go to work release two weeks ago but cannot because of COVID. They feel this is unfair when chain buses are coming in from all over the state but DOC says they have stopped all transfers.	The OCO substantiated the concern about a delayed work release transfer. However, all transfers were halted due to COVID.	Substantiated Without Resolution
Larch Corrections Center			
67.	Sergeant reportedly placing combination locks on incarcerated individuals' personal lockers on backwards, making it difficult to open the locker. Incarcerated	The OCO contacted Correctional Unit Supervisor who explained that he wrote an all staff email with directive to place locker combination locks on	DOC Resolved

	individual holds emergency inhaler for asthma in the locker and is unable to access it in a timely manner when the combination lock is on backwards.	face-forward to ensure easy access to incarcerated individuals.	
	Mission Creek Corrections Center for Women		
68.	Person reports that they were placed in a unit with no heat. This was during the extremely cold weather in late December.	The OCO notified the facility of this concern immediately. The heat was repaired after the weekend.	DOC Resolved
69.	Person says that they have been placed in Therapeutic Community (TC) treatment without being assessed.	The OCO was unable to substantiate a violation of policy. The OCO raised this concern with TC administration. Staff explained the process for evaluation scoring and that overrides may be made depending on various factors for substance abuse treatment on an individual basis.	No Violation of Policy
70.	Person states that their client has been assessed incorrectly. Person should not be in the TC program.	The OCO was unable to substantiate a violation of policy. DOC substance abuse policy allows DOC to consider anything in a person's file that is substance use related in determining whether that person needs treatment. This office explained that this individual will have to complete TC treatment before being released back into general population.	No Violation of Policy
71.	Person reports that she is not court-ordered to complete treatment nor was her conviction related to substance use. However, DOC placed her in the TC program. Because of the length of time required to complete TC she would not then be eligible to apply for the Community Parenting Alternative (CPA) program.	The OCO was unable to substantiate a violation of policy. The OCO's review showed that DOC prioritizes treatment over CPA programming. Therefore, this individual will need to complete treatment before she can be eligible for CPA.	No Violation of Policy
	Monroe Correctional Complex		
72.	The individual was sent to medical and when they came back their bedding was gone due to a cell search. The individual waited until later in the evening to get more bedding and was told that they were receiving an infraction for misusing their bedding and would be charged $8.75 per blanket.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
73.	The incarcerated individual was given a breathalyzer test in a darkened day room and was not given a waiver to sign. Their mouth	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint	Administrative Remedies Not Pursued

		was not checked for any objects before the test, and they were not told their results. Staff did not follow policy when they were testing them for drugs and alcohol.	until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	
74.	Twin Rivers Unit	Person reported that the individual for whom they work as a therapy aide has been declining rapidly in his abilities to take care of himself.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
75.	Intensive Management Unit	Person is experiencing adverse effects from medication ordering error. He feels he has been inappropriately isolated following reporting these effects.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
76.	Twin Rivers Unit	The individual has been approved by headquarters to have bleach in their cell, but staff wrote them up for having bleach in their possession.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
77.		The incarcerated individual was breathalyzed in a darkened day room, and all pods were watching them. The staff did not do a mouth check before asking them to blow into the breathalyzer. The person was not given a waiver to sign before being tested. The staff did not follow the policy for breathalyzing this individual.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
78.		The individual has an advanced medical condition that requires additional treatment and medication. The individual has not been provided the required medication or scheduled for additional treatment.	The OCO provided assistance. The OCO alerted facility health services leadership of these concerns. DOC later verified that medication has been provided and the individual is scheduled for additional treatment.	Assistance Provided
79.	Twin Rivers Unit	Individual reported that he may have cancer and was receiving a specific	The OCO provided assistance to the individual. The OCO requested that	Assistance Provided

		pain medication prior to transfer to MCC. His request for this medication was denied. Individual has requested treatment and monitoring of current medical condition.	medical meet with the individual about pain management options available under the DOC Health Plan. Subsequent testing determined that a mass on the individual's liver was benign and did not warrant removal at the time but continued monitoring of the individual's condition and additional testing would be performed.	
80.	Washington State Reformatory	Patient reports he is not receiving the correct renal diet. He reports having grieved several times and come to many resolutions that DOC is not following through on. The patient states something is either missing, short, or wrong in their meals every day.	The OCO provided assistance. This office contacted DOC staff in Health Services and the kitchen. The OCO's review determined that the DOC is not able to purchase the renal meals from the outside hospital but has addressed the diet concerns by assigning a kitchen team leader to ensure the patient's meals are correct every day. DOC staff have also assigned a staff member to notify if this individual encounters meal problems so that DOC can provide an immediate remedy.	Assistance Provided
81.		Individual has chronic pain issues that supportive clothing provides relief from. Wants OCO to confirm HSR for clothing and order for supportive clothing from commissary.	The OCO provided assistance. The OCO contacted facility health services staff, who were then able to issue the HSR and ensure the delivery of the supportive clothing.	Assistance Provided
82.	Washington State Reformatory Unit	Patient submitted resolution requests regarding delays in being seen by provider after submitting an urgent kite. They feel there should have been no delay in MCC medical staff meeting with patient about this problem.	The OCO provided assistance. This office reviewed the person's resolution requests and were able to confirm a delay in care, changing medication schedule, and the kite response times. The OCO contacted Health Services management about this concern and was later able to confirm that the DOC was reviewing their processes to prevent these delays from happening again.	Assistance Provided
83.	Twin Rivers Unit	Individual had a heart attack and was prescribed two medications for daily use. The medications ran out and were not promptly refilled. The individual attempted to see the assigned provider but was unsuccessful.	The OCO provided assistance. This office contacted medical and was informed that the prescriptions have been fulfilled and were awaiting pickup by the individual.	Assistance Provided
84.	Washington State Reformatory Unit	Patient reports multiple medical concerns. He has been sent to specialists but no remedy has come from the appointments.	The OCO provided assistance. The OCO alerted DOC staff, who then made appointments for the patient to be seen before the end of the month by a local medical provider. DOC staff also made arrangements for release planning with his social worker for care in the community.	Assistance Provided

85.		Patient is having trouble accessing appointments for approved healthcare. Patient's surgeries have been approved for many months but cannot seem to get DOC to set up any appointments.	The OCO provided assistance. The OCO alerted DOC; DOC then scheduled the appointment with surgeon.	Assistance Provided
86.		Family member reports the patient had been taken off medications before the weekend when he would not be able to see a provider.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted Health Services management and were informed the patient had been seen very recently and the medication issue had been resolved.	DOC Resolved
87.	Washington State Reformatory	Family member of an incarcerated individual reports that individuals housed in the old segregation unit do not have access to water, power, heat, phones and are getting very limited yard time.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC provided individuals housed in this unit with access to a phone, electricity and provided them with bottled water as the tap water in the older building could have been unclean due to the age of the building. DOC moved individuals in other areas of the building all to the same unit where they could access more amenities during their quarantine.	DOC Resolved
88.	Twin Rivers Unit	Patient has severe pain and had been seen for this issue but feels the treatment did not address the seriousness of his symptoms. He felt the need to call a medical emergency, but this would not change the treatment or diagnosis.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC has scheduled the requested evaluations. The OCO substantiated the delay of care due to appointment scheduling mistake.	DOC Resolved
89.		Patient reports being denied an appointment with outside specialist.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The patient reported to this office that he was able to meet with provider and was told they would be scheduled for an outside appointment as requested.	DOC Resolved
90.		Patient's surgery was scheduled for last year, was canceled due to COVID, and has not been rescheduled.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed resolution requests and confirmed surgery is scheduled.	DOC Resolved
91.	Twin Rivers Unit	Person is writing with concerns that staff are not following the directives from headquarters regarding N95 masks being available for all staff and incarcerated individuals within DOC custody. Person reports that they have been able to access masks as needed previously, but other staff denied a replacement mask.	The complainant notified the OCO that the issue had been resolved prior to OCO taking action on this concern. The person stated that they have been issued a new N95 mask and that staff are aware of the memo issued on the same topic.	DOC Resolved

92.	Special Offender Unit	Individual has had difficulties filing grievances due to his inability to read and write. He says the grievance coordinator is unwilling to help him. He also is unable to get any assistance reading his Bible, mail, and legal documents.	DOC staff resolved this concern prior to the OCO taking action on the complaint. This individual is currently in the transfer pod awaiting transfer to another facility. The CUS was able to obtain a Bible reader for him and has been communicating with him regularly to address his needs.	DOC Resolved
93.		The incarcerated individual reported that this facility is slowly implementing the new mattresses. People are not being issued the new mattresses, but instead are getting them as an incentive.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The DOC is in the process of ordering more mattresses so that everyone gets one. This office wrote a letter to the individual explaining the details of the mattress replacement process.	DOC Resolved
94.	Twin Rivers Unit	Person states he is unable to get an outside consult because he declined a treatment that he had already tried.	DOC staff resolved this concern prior to the OCO taking action on this complaint. Patient saw Telehealth provider for medical concern.	DOC Resolved
95.		Individual was injured in a truck accident years ago and reports nerve damage and pain as a result. Before being transferred a series of x-rays were taken and the individual was scheduled to see a neurosurgeon. Following the transfer, the provider at the new facility was not aware that the neurosurgeon appointment had been canceled as a result of the transfer. Individual needs to have the appointment rescheduled and receive appropriate care.	The DOC resolved this issue prior to the OCO taking action on this complaint. The OCO contacted health services at the other facility and confirmed that the individual is scheduled for a medical appointment and the facility medical director is reviewing his concerns.	DOC Resolved
96.		Person has been asking for COVID booster for two months and has been told it is unavailable. He has sent kites which have been unanswered. Also, telemedicine connection failed, and now unit is locked down and is unable to see provider.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted DOC and were informed the patient's living unit is finished with quarantine lockdown and booster shot has been received. DOC also stated the telemedicine appointment was cancelled due to technical issues and will be rescheduled.	DOC Resolved
97.	Twin Rivers Unit	Incarcerated individual requests access to the law library as soon as possible to work on a case. They were told by staff they do not qualify for priority access.	DOC staff resolved this concern prior to the OCO taking action. Incarcerated individual was granted access to law library.	DOC Resolved
98.	Intensive Management Unit	Incarcerated person has requested visits from mental health but has not been seen for several months. Patient states mental health is now	DOC staff resolved this concern prior to the OCO taking action. The OCO confirmed that DOC provided this person with a mental health appointment prior to this office	DOC Resolved

		allowed to not provide follow up appointments.	inquiring. The OCO also confirmed that a follow up mental health appointment has already been scheduled for this person.	
99.		Person reports that his medical records contain someone else's information. He has no idea where the information came from.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted DOC and were informed that DOC staff had located the incorrectly filed entries and removed them.	DOC Resolved
100.	Intensive Management Unit	The incarcerated individual is in the intensive management unit and has a very flat mattress. They have tried to resolve this issue with medical, who tells them to talk to staff and then staff tells them to talk to medical.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The DOC has replaced the old mattresses that were in the intensive management unit. The individual received a new mattress today.	DOC Resolved
101.		The incarcerated individual reports that they are being denied the ability to order a Paralegal Correspondence course.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The Dean of Education had already begun the process of approving this request.	DOC Resolved
102.		The individual reports that the resolution staff are not working on his concerns. The grievances are being delayed and sent back or returned to the individuals asking for a rewrite. This person feels that staff are doing this intentionally.	The OCO provided information regarding the status of this person's grievances. This office reviewed the incarcerated individual's grievances and did not see any indication of staff intentionally asking for re-writes or avoiding their grievances. This office wrote this person a letter with this information.	Information Provided
103.		The individual reports that the facility is not providing indigent persons basic hygiene supplies such as toothpaste and soap. The individual has mental health needs and doesn't feel cared for by staff.	The OCO provided information regarding hygiene kits that are supplied to all individuals when they first arrive at the Intensive Management Unit. The OCO also verified that this person is being seen by mental health. This office wrote a letter to this person explaining that they can kite the property sergeant for needed indigent hygiene items.	Information Provided
104.	Twin Rivers Unit	Person says the staff should been doing their jobs during count and conduct a living breathing count as outlined in DOC policy. They may now never know if person found deceased in the unit could have been saved had they been found earlier. After the medical provider arrived on scene and called off life saving measures, DOC staff were standing around laughing out loud and the	Provided information to person that an unexpected fatality review will be conducted regarding the recent fatality at MCC. Person also had additional concern regarding JPay; provided information to them about how to contact JPay directly as OCO cannot impact change on third party vendor issues.	Information Provided

		deceased person was lying in the hallway.		
105.		The incarcerated individual put in a request for a furlough to go to their mother's funeral. DOC denied their request because the funeral party could not provide a guest list.	The OCO provided information regarding the person's furlough request. The OCO contacted the DOC about this concern. and asked how this person could view the video of their mother's funeral. The DOC agreed to have the incarcerated individual's family provide a copy of the funeral video on an electronic storage device that staff would let them view. This office wrote this person a letter explaining the next steps to the incarcerated individual.	Information Provided
106.		This person's early release date was recalculated and extended by one year. The individual does not understand why he is not receiving any of his earned good conduct time that he acquired in county jail.	The OCO provided information regarding the reason the estimated release date changed. The DOC provided information that credits were applied which should not have been. OCO wrote a letter to this person relaying information from the DOC.	Information Provided
107.	Twin Rivers Unit	The individual requested to move to a different wing in their unit. They report they are being harassed and discriminated against by staff and other incarcerated individuals.	The OCO was unable to substantiate the concern due to insufficient evidence. This office could not establish that the individual needed to move to the wing they requested. This office wrote a letter to the individual with this information.	Insufficient Evidence to Substantiate
108.	Intensive Management Unit	Loved one reports that incarcerated relative was in a serious accident and went back for a violation as a result of the accident. He was provided a wheelchair due to his injuries from the accident. Recently he got into an argument with a nurse who had tried to take his wheelchair from him because he still needs the wheelchair. The nurse then told officers that he was being belligerent, which resulted in the officers wrestling him. His injuries were made worse during this use of force.	The OCO was unable to substantiate the concern due to insufficient evidence. Video of this incident was no longer available. The OCO did verify that he has a health status report (HSR) for a wheelchair and restricted standing. He was also moved from IMU to a living unit.	Insufficient Evidence to Substantiate
109.	MSU	The incarcerated individual had two money orders mailed to him that he never received. He was told that it was not a grievable issue and was asked to re-write his concern	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO contacted the DOC about this concern. The DOC reported that there is no way to track the money orders sent to individuals.	Insufficient Evidence to Substantiate
110.		The incarcerated individual reports his therapist told him that they heard he was having problems with	The OCO was unable to substantiate the concern due to insufficient evidence. Evidence does not exist that	Insufficient Evidence to Substantiate

		his cellmate. The incarcerated individual says that this is not true and has taken this to a level three grievance. This person reports that staff that have been interviewed are not telling the truth.	would prove or disprove the allegation that a staff member lied in this situation.	
111.	Special Offender Unit	Patient states they were injured during a use of force and the report claims that they were not injured.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed records related to the incident and were unable to substantiate claims that DOC staff caused the injury due to the injury being documented prior to incident.	Insufficient Evidence to Substantiate
112.	Washington State Reformatory	Individual was given an infraction for allegedly inciting a group demonstration. Individual claims there was no evidence for infraction, but they appealed and infraction was upheld. Individual reported that the hearings officer made statements while recording was paused that evidenced the hearing officer's conflict of interest after past interactions.	The OCO reviewed the hearing but was unable to substantiate the claim. No inappropriate statements were made on the recording listened to by OCO staff; however, the recording was paused for deliberation for some time. It is possible that bias may have been shown during that time. Without a recording of the entire hearing, including deliberation time, this office is unable to substantiate the claim of bias. DOC agreed to review the hearing and related information, but was unwilling to overturn the infraction, for the same reason.	Insufficient Evidence to Substantiate
113.	Twin Rivers Unit	Person says that they were assaulted by a staff member. After they filed a complaint, staff started to retaliate against him and threaten him.	The OCO was unable to substantiate the concern due to insufficient evidence. In a claim of retaliation, a protected action which was followed by a negative action from staff must be proven. Those two facts must be close in time, or have some other clear relationship, to substantiate a claim of retaliation. The infraction received appears to have its own independent basis to support upholding the infraction. Without additional evidence to suggest an underlying motive from staff, this office is unable to substantiate a claim of retaliation.	Insufficient Evidence to Substantiate
114.		The individual says that they are being specifically singled out and targeted by the administration to deny them various privileges, specifically a purple tag, using memos and behavior observation entries.	The OCO was unable to substantiate the concern due to insufficient evidence. The purple tag incentive program was created specifically for this unit. This office could not find any evidence to substantiate that staff are targeting this person.	Insufficient Evidence to Substantiate
115.	Special Offender Unit	The individual reports that another incarcerated individual was allowed into his cell by staff and then that individual attacked him. This person	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO contacted the DOC about this concern and this office	Insufficient Evidence to Substantiate

		was moved to segregation and staff did not investigate the incident. This individual says the extended stay in segregation has worsened their mental illness.	could not find evidence to substantiate that a staff member opened the incarcerated individual's door on purpose.	
116.	Twin Rivers Unit	The incarcerated individual received a cell confinement sanction that should have only lasted 30 days. Staff paused their sanction stating that it was a mutual agreement. The incarcerated individual did not agree to having their sanction paused.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO contacted the DOC about this concern and received conflicting information between what the incarcerated individual has reported and what DOC reported. Evidence that would prove what the individuals had agreed upon, if anything, does not exist.	Insufficient Evidence to Substantiate
117.		Incarcerated person says that staff continue to racially target him. In this instance, incarcerated person claimed they received another infraction for something they did not do. The incarcerated individual states that this is the second time this has happened, and they believe this is a staff misconduct issue.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the incarcerated person's disciplinary record, and no infraction seems to have been issued for the incident in question. The incarcerated person grieved staff misconduct, but that grievance did not escalate beyond Level 0 because the infraction was not issued. The OCO previously reviewed the incarcerated person's prior infraction (the other of the two incidents they raised) and was unable to substantiate a claim of racial bias in that infraction. There is insufficient evidence in this case to establish that a pattern of racial bias or staff misconduct exists toward this incarcerated person.	Insufficient Evidence to Substantiate
118.		The incarcerated individual reports that the Indeterminate Sentence Review Board is using behavior observation entries (BOEs) to add 120 months to their minimum term.	The OCO was unable to substantiate the concern due to insufficient evidence. This office determined that the decision made by the Indeterminate Sentencing Review Board was not made solely on behavior observation entries. The OCO wrote a letter to this person explaining how the board arrived at its decision.	Insufficient Evidence to Substantiate
119.	Washington State Reformatory	The incarcerated individual was advised to send OCO a copy of the letter he sent to the Governor's office. He asked the OCO to follow up and see if the letters made it to the intended recipients.	This complaint did not allege any violation of policy, procedure, or law. The OCO does not follow up on letters written to other offices. This office wrote a letter to this person explaining this.	Lacked Jurisdiction
120.		Friend or family member of an incarcerated individual reports 41 COVID-19 positive people were	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The DOC confirmed that the unit in question	No Violation of Policy

		moved into a unit with people who did not have COVID-19.	was turned into a COVID-19 isolation unit for COVID-19 positive incarcerated individuals per the instruction of the DOC COVID-19 Incident Command team.	
121.		Incarcerated individual reports that health services provided him with a health status report (HSR) for an ADA cell. However, the sergeant refused to honor it and threatened to remove him from facility.	The OCO was unable to identify evidence to substantiate a violation of policy by DOC. DOC is following guidelines in DOC 420.140, which states that all single cell requests (ADA cells at this facility are all single cells) will need to go through the facility medical director and be approved through the HCSC. The HSR that was written did not follow the process. DOC reported to the OCO that they have been working with medical staff to train them on the policy. The OCO informed this individual that he will need to speak with his medical provider for this request.	No Violation of Policy
122.	Twin Rivers Unit	Patient was scheduled for COVID booster and flu shot but during immunization clinic the unit was locked down for mass cell search and medical was asked to leave.	The OCO contacted DOC Health Services management and were informed there have been some delays due to facility operations. However multiple opportunities exist on the living units for this person to receive the vaccinations, both scheduled on the callout and in a walk-up capacity.	No Violation of Policy
123.	Washington State Reformatory	Patient has reported a need for a diet that will not exacerbate his medical condition. Patient was supposed to be scheduled to see two specialists after a medical emergency, but these follow-ups have not occurred. Patient also requested medications be changed.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC has provided a mainline alternative, which the patient refused. A Care Review Committee consult regarding specialized diet is pending. The OCO confirmed that the patient is scheduled for cardiology, and an endocrinology appointment is pending.	No Violation of Policy
124.		Incarcerated individual believes that there is an error in the DOC's new calculation of their earned release date.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO contacted the DOC about this concern. The DOC stated that the individual's release date was initially calculated incorrectly. The sentence was recalculated, and additional time was added. This office wrote a letter to the incarcerated individual reiterating that the individual's current release date is correct.	No Violation of Policy
125.	Twin Rivers Unit	The individual had a Prison Rape Elimination Act claim filed against them. They went to the Intensive	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. This office	No Violation of Policy

		Management Unit for 30 days before being moved to a different tier. The claim made against them was false and they were forced out of the unit unjustly. The individual would like to be moved back to their old unit and have their job back.	wrote a letter to the incarcerated individual explaining DOC 490.850 and acknowledging that most of the individual's requests were met by the Department of Corrections.	
126.		This patient's Care Review Committee (CRC) review for a specialist's evaluation continues to be re-scheduled. It is now 28 days past the initial date.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO contacted DOC Health Services management and were informed that all of the patient's consults have been presented at this time.	No Violation of Policy
127.		Patient was expecting to return to the In-Patient Unit for pain management that was approved by Care Review Committee (CRC). The patient believes it should be scheduled due to a CRC approval letter they received.	The OCO contacted Health Services management and the Facility Medical Director. The patient completed the inpatient treatment before he received the approval letter for that treatment. Patient has a treatment plan moving forward.	No Violation of Policy
128.	Twin Rivers Unit	Family member reached out reporting that their loved one received two infractions and his JPay player was taken away, despite that not being a listed sanction. The individual still does not have access to player.	OCO reached out to the individual in question but did not receive a response indicating that the individual wanted OCO to move forward with an investigation.	Person Declined OCO Involvement
129.		Person is immuno-suppressed. Throughout quarantine they have been exposed to people who had tested positive for COVID.	This person was released prior to the OCO taking action on the complaint.	Person Left DOC Custody Prior to OCO Action
130.	Special Offender Unit	The incarcerated individual reports that three months prior to their early release date they were evaluated to determine if they will be identified as a "sexually violent predator" (SVP). Now the individual must go before a judge to determine whether civil commitment will be upheld. This person reports there is a delay in the SVP determination being made.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The individual does have a civil commitment hearing, but no timeline has been established for the hearing.	Substantiated Without Resolution
131.	Special Offender Unit	The individual reports the TV reception in the unit is still poor, and they are being charged for the cable service. They filed grievances two years ago and were told the reception was being repaired. This person reports the reception is still terrible.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The DOC acknowledged that there is an issue with the TV reception and reported that they are working on a solution. This office wrote a letter to this person explaining the current cable situation.	Substantiated Without Resolution
132.		Person was housed in segregation and pressed the emergency button to alert staff to suicidal ideation.	The OCO substantiated this concern without resolution. The CO did leave the unit and the Correctional Unit	Substantiated Without Resolution

		Staff did not respond and he attempted self-harm. Staff arrived 30 minutes later and did not respond according to protocol.	Supervisor was made aware of the incident. The grievance is still under investigation.	
133.		The individual says that they tested negative for COVID. However, they were moved around to several different units, some being COVID positive. Ultimately being quarantined for 14 days then isolated for an additional 10 days.	The OCO was able to substantiate this concern but was not able to achieve a resolution. This office determined the individual was moved several times during quarantine.	Substantiated Without Resolution
134.		The incarcerated individual was in the Intensive Management Unit (IMU) and passed several COVID tests but was still held in IMU well past the 14 days. The medical staff would not give them their test results.	The OCO was able to substantiate this concern but was not able to achieve a resolution. This office determined the individual was kept in quarantine for more than the recommended 14 days.	Substantiated Without Resolution
135.		The individual says that they tested negative on a COVID lab test and rapid test; however, their cellmate tested positive on the same test. People in their unit who tested positive and negative were not separated until a day later.	The OCO was able to substantiate this concern but was not able to achieve a resolution. During an onsite visit, OCO witnessed the complex issues of individuals housed in this unit for quarantine. This office wrote a letter to the individual confirming the information and giving an update on our COVID tracker.	Substantiated Without Resolution
136.	Special Offender Unit	The individual reports that staff are not processing emergency grievances correctly.	The OCO was able to substantiate this concern but was not able to achieve a resolution. This issue was already addressed last month. This office explained to the individual that the officer did not yet know the protocol at that time.	Substantiated Without Resolution
137.	Special Offender Unit	This person reports that staff violated DOC policy 500.100 by refusing to place his emergency grievance with a Lieutenant regarding threats and harassment by another incarcerated individual.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The OCO contacted the DOC about this concern. The DOC substantiated the complaint by explaining the correctional officer was new and was unaware of the emergency grievance policy.	Substantiated Without Resolution
138.		Caller stated an individual had died at Monroe. He said DOC was not doing appropriate tier checks and the lifesaving bag they brought to the cell was incomplete.	This case was reviewed by the unexpected fatality review team. RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. UFR-22-008 is publicly available on the DOC website.	Unexpected Fatality Review
	Olympic Corrections Center			

139.	The individual was placed in segregation for nine days because they had contact with a guard who tested positive. The individual was then moved, only to be subjected to a separate quarantine from the entire unit, which caused tension.	The OCO informed this person that this office is not opening investigations for individual cases in relation to DOC policies 410.030, 410.430, 410.050, 670.000 and RCW 43.06.220 in its handling of COVID-19 concerns. However, OCO has been actively monitoring DOC's response to COVID-19, including preventative actions. This office has been gathering COVID-related information from incarcerated individuals and will make additional recommendations to DOC for further improvements where needed and as appropriate.	Information Provided
Other - Out of State			
140.	Person says they were sent out of state and have concerns why they there sent to a state far away. Person is also concerned DOC rushed to send them out of state pending the state being under pressure to do so.	The OCO was unable to substantiate a violation of DOC Policy 380.605 Interstate Compact. Due to Security Threat Group activity, the incarcerated individual was sent out of state. DOC is not able to select a specific state for an individual to transfer to; DOC asks multiple states and the transfer will go to the state that will accept the transfer.	No Violation of Policy
Other			
141.	Person disputes the release date that the Records department has on file for him. He lost 30 days of earned time due to a violation that he received while on community custody. He disagreed with the violation, which was for failure to check in, because he states he was in the hospital with COVID.	The individual's violation occurred while in community custody; OCO does not have jurisdiction to investigate concerns that occur outside DOC facilities, including incidents that occur on community custody.	Lacked Jurisdiction
142.	Caller reports that he was unjustly taken off electric home monitoring. He states that he was removed from GRE because he had the "Chime" banking app installed on his phone.	The OCO was unable to substantiate a violation of policy. The OCO's review found that his infraction was due to unauthorized stops and unauthorized selling of items.	No Violation of Policy
143.	Incarcerated individual says they were falsely convicted due to inadequate counsel.	OCO does not have jurisdiction over crime of conviction or sentencing.	Lacked Jurisdiction
Peninsula - Kitsap County			
144.	Person reports they tested positive for COVID-19. They were then taken to isolation camp. Later they were brought back to work release with two other people. Person does not understand why facility has not	Facility was immediately notified of concern. Women were moved back out of isolation after the weekend once testing came back negative.	Assistance Provided

	provided their results and is confused by isolation procedure.		
	Progress House - Pierce County		
145.	Person reports they are concerned over facility not following safe COVID-19 procedures. Staff is not wearing gloves and letting people that are sick with COVID use the same bathrooms as people that are not sick. They are concerned about the spread of COVID in the facility.	The OCO notified the facility of this concern immediately. Facility agreed to implement extra precautions to limit the rate of infection spread.	Assistance Provided
	Reynolds - King County		
146.	Person reports staff took away their cellphone due to an infraction for being out of bounds. This infraction is outside the scope of the Cell Phone Agreement document that the individual signed.	The OCO contacted the work release supervisor and was informed that the person is being given access to a state issued cell phone.	No Violation of Policy
147.	Person reports that too much time was imposed for an infraction for which they were found guilty.	Person was released from the work release before the OCO received the relevant infraction packet. No impact on time remaining in partial confinement.	Person Left DOC Custody Prior to OCO Action
	Stafford Creek Corrections Center		
148.	The incarcerated individual is concerned about a conversation they had with DOC resolution staff. The staff member spoke to them in a hurtful manner.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
149.	The incarcerated person reports they are being harassed and retaliated against by other incarcerated individuals while at work. He reported this concern yet nothing had been done.	The incarcerated person has not pursued the internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO did report his safety concerns to the DOC administration.	Administrative Remedies Not Pursued
150.	Incarcerated individual reports lunch meat was left out on the counter at 6pm and remained unrefrigerated until breakfast at 7:30am. Other food concerns: a protein source (sunflower seeds) was removed and replaced with low-grade tortilla chips. Lunch boats are handed out for breakfast every morning, kites go	The incarcerated person has not pursued the internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

	unanswered and kitchen management turns off the heat for the workers in the kitchen. They are also rarely getting published menus and utensils. Milk is also left out overnight.		
151.	Incarcerated individual reports concern that DOC is not corresponding with his attorney by sending the attorney documents and information.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
152.	Incarcerated individual submitted a public records request (PRR) but over half of the request was missing. Incarcerated individual followed administrative remedies and has not yet had their resolution request completed. The individual would like their PRR fulfilled.	The incarcerated person has not pursued the internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
153.	Incarcerated person stated they stopped going to work in the kitchen due to concerns about COVID safety and were subsequently infracted for refusing an assigned job. Incarcerated person had seen that the OCO previously published a report on erroneous infractions for refusing work assignments during the first wave of COVID, and felt his situation was analogous to those infractions (which the OCO advocated to overturn). Incarcerated person wants this infraction off his record and his points given back.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
154.	Patient reports that he is unable to meet with medical provider. He is experiencing symptoms that are concerning him.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO's review determined that the person was able to access their provider but had declined treatment shortly before filing this complaint.	Administrative Remedies Not Pursued

155.	The individual feels targeted by staff due to several infractions and being moved to the Veterans pod when they were not a veteran. They also felt pressured to sign a release for what they believed to be monetary gain.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
156.	Family member reports that the patient is getting very sick again from a chronic condition that is not being addressed by medical.	The OCO provided assistance. The OCO alerted DOC to the patient's needs. The patient's diet was corrected, the patient has been seen by health services, and an offsite specialist appointment has been scheduled.	Assistance Provided
157.	Patient stated he has requested his "keep on person" meds for three weeks and has not received a response.	The OCO provided assistance by contacting DOC. DOC staff then located and provided the medication.	Assistance Provided
158.	Incarcerated person is an out of state transfer who wants to return to Oregon or be allowed to participate in reentry. He states he had to grieve to receive a custody facility plan and he is not allowed to program.	The OCO provided assistance. This office alerted DOC of these concerns. The DOC agreed to move him to a lower custody. His next custody facility plan will occur soon. Per DOC Interstate Compact policy 380.605, both states need to agree if there is a custody promotion lower than medium.	Assistance Provided
159.	Person has not been receiving resolution request responses. Person is concerned about chronic care management appointments prior to release.	The OCO provided assistance. The OCO contacted DOC staff and the person has been interviewed for resolution by the facility health services manager. The person is also scheduled for reentry planning and chronic care management follow up within the month. They will be monitored by reentry nurse to ensure they are ready for release.	Assistance Provided
160.	Incarcerated individual reports that DOC staff have not responded to a resolution request within the policy driven timelines. Individual would like a response as it is a serious concern.	The OCO provided assistance. This office confirmed the resolution request response had not been responded to within the guidelines outlined in policy. The OCO contacted the resolution team and confirmed that after OCO outreach the level two response has been completed and is awaiting signature.	Assistance Provided
161.	Incarcerated individual reports he cannot access the law library and has not had access since his entry into WA DOC.	The OCO provided assistance. The law library was previously closed due to the COVID-19 outbreak and has now reopened. DOC explained the process for individuals to gain access which this	Assistance Provided

		office was then able to relay to the individual.	
162.	Person was transferred from camp over a month ago and never received any of his property or medication. He has grieved medical and it has been weeks with no change. He has been unable to get seen by mental health or medical.	OCO provided assistance by alerting the DOC of this person's needs. The patient is now being seen by medical and mental health staff.	Assistance Provided
163.	Family member communicated that a patient's meals in the quarantine unit were being underserved and served late.	The OCO provided assistance by notifying DOC management of the population meal concerns as well as patient-specific concern. The OCO also confirmed with Health Services that medical staff saw this patient the same day.	Assistance Provided
164.	Patient states that the delayed diagnostics for a chronic health condition are causing undue delays in treating cancer.	The OCO provided assistance by alerting DOC; the patient has now been seen by an outside specialist and started on a new treatment plan.	Assistance Provided
165.	Patient has not been to see outside specialist and has been having emergencies related to chronic condition.	The OCO was able to provide assistance. The OCO notified the DOC of these concerns. The patient was then seen by outside cardiology and has had local follow up. Facility Medical Director is now closely monitoring this individual.	Assistance Provided
166.	Incarcerated individual states he was given a false infraction. He was unhappy with the first OCO investigation and has asked the OCO to rereview the concern.	The OCO declined to reopen this case as a closed case review had already been completed previously.	Declined
167.	Loved one of an incarcerated individual reports the conditions of confinement during the COVID-19 outbreak are poor. The loved one reports that food is cold and that individuals are not getting enough time out of their cells.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC changed the way they were transporting food to the unit and have added more kitchen staff to get the food out to the units in a timelier manner. A yard time schedule was newly created by DOC administration with the intention of creating more yard access.	DOC Resolved
168.	Complainant requested that the OCO follow up on an incident that caused injury to an elderly incarcerated individual.	The OCO followed up with the superintendent and health services regarding harm that was caused to an incarcerated individual when he was attacked. The incarcerated individual received care at Harbor View Hospital and follow up at the facility. Charges will be filed against the incarcerated individual who harmed this individual.	DOC Resolved

		DOC is conducting a critical incident review.	
169.	Loved one of an incarcerated individual is having issues with facilitating video visits with her son and his father, who is incarcerated. The loved one reports that DOC has imposed conditions for the visits with her son that are unmanageable and cost her a lot of money. She would like to have the imposed conditions removed so she can facilitate the visits at home and not have to pay a third party to be present.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The DOC removed the condition of a third-party supervisor being required during visits with their son and now the loved one herself can monitor these visits.	DOC Resolved
170.	Loved one contacted the OCO about COVID booster shots not being available for loved one.	DOC staff resolved this concern prior to the OCO taking action on this complaint. Booster clinics are being scheduled.	DOC Resolved
171.	Person refused a cell assignment and stated he did so because of safety concerns after his cellmate threatened him. He was placed in the IMU for his refusal and believed he should not have been.	The OCO reviewed the individual's disciplinary record for this incident. The infraction was dismissed by DOC. The individual's placement in IMU is subject to DOC classification and safety decisions. Because the infraction has been dismissed, OCO considers DOC to have resolved this matter.	DOC Resolved
172.	Incarcerated individual reports that he has not received responses to grievances. He also reports problems interacting with the ADA coordinator regarding property.	DOC resolved these concerns prior to the OCO taking action on this complaint. OCO review determined that the grievance was responded to and included instructions for picking up ADA property in question.	DOC Resolved
173.	This person was diagnosed with a chronic illness. The symptoms always come back, and this person must push for medical to prescribe them again. This has happened multiple times.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The medication in question has been reordered.	DOC Resolved
174.	This patient was told by a correctional officer that they were not getting their medication that day.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted DOC and were informed the patient received their medication the same day.	DOC Resolved
175.	Individual’s appointments for surgery have been cancelled repeatedly. Individual needs to have surgery scheduled and performed.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted the facility health services manager and confirmed that the individual received surgery as scheduled.	DOC Resolved
176.	Patient says that medical is refusing him medical care. Medical at the	DOC staff resolved the complaint prior to OCO action. The OCO verified the	DOC Resolved

	facility has refused to see him or give him the cream prescribed by the outside provider he saw. He also is not being seen for his pain management needs.	incarcerated individual did receive his topical medication and pain medication.	
177.	Incarcerated individual reports payment for a musical instrument was lost by DOC.	The DOC staff resolved the complaint prior to OCO action. The OCO was informed the payment was located and sent out by DOC staff.	DOC Resolved
178.	Incarcerated individual was placed in segregation and his hearings were delayed for infractions.	The DOC staff resolved the complaint prior to OCO action. This person was moved back to general population. One of his infractions was dismissed and he has hearings scheduled for the two remaining.	DOC Resolved
179.	Family member reports their loved one has not been able to get a new prescription for glasses in four years.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO provided the family member with self-advocacy information for the patient regarding resolution requests.	Information Provided
180.	Family member reports the patient was unable to access medications for 12 days due to the prescription being expired. Medical told him he would be added to the pill line, then the unit was locked down for COVID.	The OCO confirmed the patient has access to the medications on pill line and has not pursued internal resolution of this concern. The OCO provided information to the family member.	Information Provided
181.	Family member reports the patient was denied dental care. They were told the dentist suggested buying Sensodyne toothpaste from commissary but the toothpaste did not treat the problem.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO provided information to the family member.	Information Provided
182.	Person says that nothing is being done to protect incarcerated people from being infected with COVID by staff. Individuals are punished during an outbreak with no recreation time and extreme in-cell times. Staff only wear PPE to protect themselves from infected incarcerated people. Mask policy is not enforced equally. Staff are also abusing authority by	The OCO provided information to this person about the OCO's COVID monitoring. The OCO explained that their concern was included on the COVID Tracker and their concern will be relayed anonymously to DOC leadership.	Information Provided

	withholding bathroom use, preventing microwave use, and retaliating if incarcerated people complain.		
183.	Patient is unable to access over-the-counter medications for medical issue unable to be resolved by medical. Patient states DOC's health plan has made it too expensive to treat his condition which is tantamount to denying medical care. Patient was told his only option would be to self-pay several hundred dollars for an outside appointment.	The OCO contacted DOC Health Services to request a review of this situation. DOC reviewed the patient commissary and medical encounters/requests. Patient has not purchased the available OTC medications which are generics of the medications requested in the original complaint. Medical has not received a request to be seen by a provider for this issue. The OCO provided this information to the individual.	Information Provided
184.	Patient was transferred with the understanding it was to be near a specialist to have vascular surgery. However, patient was transferred back to original facility before the surgery could occur.	The OCO contacted DOC Health Services and were informed the patient has a medical hold in place until the surgery is done. The surgery is delayed due a flood and COVID outbreak at the outside office. The OCO informed the patient that it is unknown at this time when the outside office will take appointments again.	Information Provided
185.	The individual reports that no one can tell him the amount of money that is taken out of his pay and the problem is they are taking out about 20 per cent.	The OCO provided DOC contact information and information regarding the deductions matrix as requested by the individual.	Information Provided
186.	Incarcerated person reported that DOC staff threatened during an investigatory interview to infract him for lying to hearings staff if the incarcerated person didn't plead guilty for an infraction. The incarcerated person believes this interferes with his right to plead his case.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the disciplinary materials on record for this infraction. Investigatory interviews are not recorded, so there is no evidence to substantiate whether the incarcerated person was compelled to plead guilty during an investigatory interview. The incarcerated person did not receive an infraction for lying to staff, and the disciplinary record does not evidence an attempt to issue that infraction at any point. Without further evidence, the OCO cannot substantiate a claim of staff misconduct.	Insufficient Evidence to Substantiate
187.	The individual is concerned that medical staff's comments will impact their ability to access further care for gender dysphoria.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the level two grievance, and DOC reported that this person's request for amended records was placed in their medical file, in the correct section. This office	Insufficient Evidence to Substantiate

		wrote this person a letter with this information.	
188.	Person reports delayed cancer care in retaliation for previous grievances.	The OCO was unable to substantiate that the delays in care were retaliatory in nature. The delay in follow-up was a mistake in the scheduling process DOC staff are working to fix.	Insufficient Evidence to Substantiate
189.	Person has submitted resolution requests about medical issues but has not received responses from medical or the grievance program. He believes this is retaliation for all the grievances written. He has written several kites requesting chronic pain visits, and he has expressed that the medication he takes does not work and was only meant to be on a trial basis, but he continues to receive it.	The OCO reviewed the grievances and contacted DOC Health Services. This office was not able to identify evidence sufficient to substantiate retaliation by DOC staff. The OCO was able to confirm that the patient is being seen for concerns brought to our office.	Insufficient Evidence to Substantiate
190.	Incarcerated individual reports that another incarcerated individual falsely accused him of sexual assault.	The OCO was unable to identify sufficient evidence to verify the complainant's concern. OCO's review determined that the DOC completed the investigation per DOC policy and protocol.	Insufficient Evidence to Substantiate
191.	Incarcerated individual was found guilty of a 506 infraction for making threats. He has appealed the issue and is still unsatisfied with the outcome, because he believes his request for certain evidence that would support his case was intentionally denied.	OCO reviewed the disciplinary materials supporting the infraction and found no violation of DOC policy. DOC interprets WAC 137-28-285 to mean that individuals do not have a right to review photo or video evidence, because of possible safety concerns. Individuals also do not have a right to review confidential information. The evidence that was denied to this individual was video evidence and confidential information, so DOC was within policy to deny it. There is no policy requirement that the reviewing Superintendent or designee have no prior knowledge of the infraction; the fact that the reviewer was aware of the investigation leading to the infraction does not preclude them from being able to review the appeal. Finally, the 24-hour notice waiver is not a guarantee that a hearing will happen within 24 hours; it is only a waiver of the individual's due process notice right.	No Violation of Policy
192.	Incarcerated person is in custody in Washington on an interstate compact and would like to go back to Virginia.	The individual will be sent back to his home state before his ERD. Currently his home state does not want to end his interstate compact early. DOC is	No Violation of Policy

		following policy 380.605 Interstate Compact.	
193.	Person says that DOC is not following OCO recommendation set forth in the investigative report involving 557 infractions for not programming in 2020, despite health and safety concerns regarding COVID. Person was infracted for not going to work despite communication that they feared for their health and safety at that time, and DOC is refusing to overturn or reduce their 557 infraction.	OCO reviewed the incident report, and the individual's original stated reason for refusing to work was not related to COVID-19. COVID concerns were only brought up after the fact, at the individual's disciplinary hearing. The individual has not provided any evidence to contradict the infraction report. The infraction has received substantial additional review, per OCO's recommendation in the 557 COVID Infractions Report. Additionally, the report did not mandate that all 557s be removed, contrary to the individual's interpretation.	No Violation of Policy
194.	Patient says the medical treatment he was receiving was causing him more harm than actually treating the issue. Patient is seeking clarification to the response from the OCO which did not seem to address the original complaint.	The OCO was unable to determine a violation of policy by the DOC. The patient has not requested to be seen for this issue in several months. Information was provided to the patient related to resolving concerns at the local level.	No Violation of Policy
195.	Person requested review of an infraction after they requested evidence to help their case, but that evidence was denied. Person also says that they have concerns with DOC's current lack of policy or procedure when someone is placed in the segregation unit during COVID-19 waiting for transfer and why they were placed in segregation.	The OCO reviewed the individual's disciplinary case and found no violation of policy. DOC denied the individual a supplemental test of physical evidence that the individual believed would have exonerated him, but the test would have delayed the investigation and ultimately was unlikely to have any bearing on the guilty finding (when viewed in light of all the other physical evidence against the individual). WAC 137-28-285 states that DOC has authority to deny evidence deemed irrelevant or unnecessary. Regarding the transfer pods, it is true that this information has not yet been added to policy; transfer pods are currently governed by Operational Memorandum at each facility. OCO sent the OM information for the individual's facility to him, for awareness.	No Violation of Policy
196.	Incarcerated person reported that they were given two infractions and were found guilty of one of the infractions despite inconsistent staff statements. Incarcerated person was concerned about the standards DOC staff use when making guilty findings for serious infractions.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed all the evidence which was used to support the infraction against this incarcerated person. The standard of proof currently used to support an infraction is “some evidence,” which is	No Violation of Policy

		a low standard. Multiple staff statements confirmed the finding of contraband in the incarcerated person's cell, which is sufficient to satisfy the DOC's standard of proof. Washington Administrative Code 137-25-030(2) allows the DOC to constructively attribute items found in a certain area to every individual that has control over that area (known as a "cell tag"). DOC did not violate policy in upholding the infraction.	
197.	Incarcerated individual worked in the kitchen and was not given a pay increase when others were. DOC told him that he was not eligible for the pay increase, he would like to know why.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The superintendent issued a memo stating that Class III workers compensation may be increased with approval. Approved compensation must not exceed $70 and the request for the increased compensation was to be submitted by the area manager to the superintendent. Compensation increase requests are based upon the nature of the job duties and the superintendent would review the request. If approved, notification of the increase will be sent to the area manager, incarcerated person, and local business office for "inmate banking." The increase is temporary and can be ended if there is a change in job status or by recommendation of the area manager. Not everyone was listed on the request submitted, which was at the discretion of the manager.	No Violation of Policy
198.	Individual received two infractions for the same incident; the first infraction was dismissed, but he was found guilty on the second one. Individual felt this constituted double jeopardy and believed the second infraction should never have been issued once the first was dismissed.	The OCO reviewed the disciplinary records for both infractions, dismissed and upheld. The OCO requested additional review of the second infraction, but DOC declined to overturn it. No violation of policy was found, because the second infraction was ultimately supported by evidence as required by DOC 460.000. DOC believed that, because the initial infraction was dismissed rather than given a "not guilty" finding, the re-admission was appropriate as long as new evidence was submitted. While the re-admissibility of dismissed infractions with additional evidence is not explicit within policy, it is a common practice throughout DOC.	No Violation of Policy

199.	Patient suffered a major infection and ongoing complications resulting from orders not being followed from outside provider.	The OCO reviewed relevant documents and policies. Health services followed the surgeon's recommendations and DOC Health Plan. The patient was provided information regarding requesting follow up at the local level.	No Violation of Policy
200.	Individual is seeking a transfer to a facility that will allow the individual to have access to educational programming and maintain a job with Correctional Industries and says that DOC is in violation of policy by failing to do so.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. An individual must utilize the process for facility placement requests described in DOC 300.380.	No Violation of Policy
201.	Incarcerated individual was issued infractions and had a hearing. His staff advisor was not allowed at the hearing and he was not allowed to review evidence. Individual states that this goes against DOC policy.	The OCO was unable to identify evidence to substantiate there was a violation of policy. A staff advisor was provided for this individual to help him prepare for his hearing, and a subsequent mental health assessment confirmed that he would be fully able to participate in the hearing in his own defense. The OCO reviewed the infraction report, and it was written and signed off on by appropriate staff. The individual requested a full confidential investigation report, but incarcerated individuals do not have a right to review confidential information according to WAC 137-28-285. DOC provided sufficient evidence to uphold the infraction.	No Violation of Policy
202.	Before transfer to current facility, this individual's health status report (HSR) for extra time to eat was questioned by a CO in a rude manner. Person wanted staff disciplined and the need for the HSR substantiated.	The OCO was unable to identify any evidence a violation of policy. Speech therapist concluded that HSR for extra mealtime was no longer needed now that individual has completed speech/swallowing therapy.	No Violation of Policy
203.	Person reports that they are now eligible for track one of the ESSB 5121 GRE program. However, their counselor is claiming to not know anything about this and is refusing to acknowledge or start putting in for housing or housing vouchers.	Person was released from DOC custody prior to OCO taking action on this complaint.	Person Left DOC Custody Prior to OCO Action
204.	Incarcerated individual shared concerns regarding lack of bedding (pillows) in his unit, limited time out of cells, long work schedules for some and tension in the facilities due to COVID -19 quarantine/isolation protocols.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The individual's unit staff confirmed with OCO that the unit will receive more bedding soon, but they do not have any at the moment. The tension in the facility regarding the COVID-19 restrictions such as yard times and work schedules was widely	Substantiated Without Resolution

		felt by many. DOC did alter the schedule to allow for more people from each unit to have time out. It is the understanding of this office that the work schedules are a reflection of the need for the facility to provide meals.	
205.	The incarcerated person reports they tried to send an e-filing to the courts for an active court case and DOC staff denied the e-filing. Individual requests assistance in accessing the e-filing process.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The documents were double-sided, and DOC staff reported that the court would not accept them as they were. The individual returned to the law library to e-file again after the documents were corrected, but DOC staff turned him away again due to not making it back on time.	Substantiated Without Resolution
206.	Incarcerated individual filed a resolution request related to staff conduct but it was not reviewed by the resolutions department because the individual already had five active resolution requests open. The individual withdrew all the five pending resolution requests to have the staff conduct concern investigated. After withdrawing the five requests, he was told by resolution staff that they would not re-open this resolution request related to the staff conduct concern.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The DOC explained to the OCO that there was not sufficient evidence to warrant further investigation. The DOC resolution program staff did not agree to investigate the staff conduct further.	Substantiated Without Resolution
207.	Individual reports that incarcerated person died on the day room floor due to a hypoglycemic reaction (low blood sugar) and lack of medical care.	This case was reviewed by the unexpected fatality review team. RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. UFR-22-006 is publicly available on the DOC website.	Unexpected Fatality Review
Washington Corrections Center			
208.	Person reports that they have not received the pictures that were mailed to them prior to moving to another facility.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
209.	Patient is concerned about potential long-term damage from potentially misdiagnosed/ignored injury.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the	Administrative Remedies Not Pursued

		OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	
210.	The individual reports that they were told their legal paperwork would be sent along with them when they left the county jail. They have not received it and they are in the middle of an active appeal. This person says the delays are jeopardizing their appeal.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
211.	Person is experiencing delays in getting seen by outside consultant for injury.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
212.	Incarcerated person stated that his rights are being violated while he is on administrative segregation, because a segregation hearing has not occurred. Incarcerated person also reports that the pending investigation (which placed him in segregation) is inaccurate and should be dropped.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. In this case, the OCO cannot address the individual's concerns about the pending investigation until the disciplinary process is complete. The individual was removed from administrative segregation status when he transferred to his current facility, and thus an administrative segregation hearing was not warranted.	Administrative Remedies Not Pursued
213.	The individual reports that they had Global Resolution between two counties, and all their time was to run concurrently. At this time their release date is not accurate because they did not receive all the credits for their jail sentence.	The OCO provided assistance. After the OCO contacted the DOC about this concern, jail credits were applied and the early release date changed.	Assistance Provided
214.	Person reports that they only have 11 days to get the HCSC to approve his GRE. He wants DOC to approve this; he feels that DOC staff are not doing their jobs and not checking	The OCO provided assistance by alerting DOC to this concern. As a result, the person’s application for GRE has been forwarded to HCSC. Person is waiting for a determination.	Assistance Provided

	what they need to do to get people approved.		
215.	Person was transferred from another facility after an assault. At the new facility staff told him that the unit does not have any kites or grievance forms so the person cannot reach out to staff and administration. Person feels discriminated against by staff withholding supplies because of the nature of the assault at the other facility.	OCO provided assistance by confirming with facility management that the restricted housing unit did not have kites or resolution forms. The forms were on backorder; however, staff will get forms from other units while awaiting the shipment. The OCO could not substantiate the lack of forms were due to discrimination towards this incarcerated individual.	Assistance Provided
216.	Loved one of an incarcerated person reports that the food being served is cold.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The DOC explained to the OCO that food temperatures were rapidly dropping due to the time taken to deliver the food tray to all the units. DOC staff have resolved the concern by modifying the way they distribute food trays.	DOC Resolved
217.	Person states that the release address they provided was mistaken for being in same county where the victim lives, when it is actually in a neighboring county. Being denied this address is causing undue hardship and an extension of the person's confinement past their earned release date.	The OCO reviewed the reason for the denial of the submitted release address; victim services had raised some concerns that, although not in the same county as the victim's address, the submitted release address was close enough to the victim address to cause concern. Since that denial, DOC has moved forward with a different release address in a different county that mitigates these concerns.	DOC Resolved
218.	Person is unable to access ordered medications in close observation area (COA).	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed with the patient the medication concern was resolved by the time the complaint was received by our office.	DOC Resolved
219.	Person reports that facility testing was not organized during a COVID outbreak, and because of disorganization in testing, he contracted COVID. He was not tested when his cellmates were, and then when he was tested, it was three days after his cellmate tested positive. He is high risk and feels like DOC gave no care for the positive result; he requested monetary compensation for his suffering.	This incident occurred during the initial COVID-19 outbreak in December 2020. Since that time, DOC and WCC have put significant effort into improving testing and cohorting/quarantine processes to avoid similar situations. The OCO has remained in close contact with WCC to ensure that practices are in place to protect individuals who have not tested positive. Because of the effort to update policies and increase safety since December 2020, OCO considers this matter to be resolved by DOC at this time.	DOC Resolved

220.	Incarcerated person stated that the education building at Washington Corrections Center has asbestos in the floors, and yet incarcerated individuals are being forced to attend class in the building; incarcerated person was concerned for their safety.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO requested additional information from the DOC to verify this concern, and it was confirmed that asbestos was discovered during a building renovation. DOC staff further stated that all programming had since been relocated do different areas, and no programming is currently happening in the education building. An abatement crew was scheduled to come to the facility and address the issue. This information was relayed to the incarcerated person who initiated the complaint.	DOC Resolved
221.	Patient was given medication assisted treatment injection and suffered severe side effects as a result of medication interactions.	The OCO provided information to the individual about filing a tort claim if they are seeking monetary damages. The OCO is not authorized to pursue or assist in claims before state or federal courts.	Information Provided
222.	Incarcerated person needs orthotics and had a unique pair of shoes made for them last year. However, the incarcerated person was told that they could not bring their shoes when they were transported to a DOC facility. The shoes went missing, and the incarcerated person is in pain without the appropriate orthotics.	The OCO provided information regarding his old pair of orthotics, as well as how to get a new pair. The OCO reviewed the incarcerated person's concern, and it appears that their shoes were left at the county jail facility. The OCO does not have authority over non-DOC facilities; if the incarcerated person wishes to obtain their property from the jail, they or a loved one must contact that facility directly. In the meantime, the incarcerated person was instructed to kite medical at their current facility to request assistance with current medical concerns.	Information Provided
223.	Person says that they requested to be housed in a place outside of active gang members. Person claimed they initially said no to a safe placement that was offered to them, and instead was approved to go to a different facility. Person then heard information that he may be in danger if placed at that facility, and so requested safe placement, but was denied. Person intentionally received infractions so they would be placed in solitary confinement, rather than be transferred to the new facility.	OCO reviewed the individual's current custody facility plan and inquired with DOC as to whether the individual's safety concerns were being received and assessed. DOC was not able to find any information to substantiate a safety concern for this individual. He was not originally offered safe placement, and if his concerns were substantiated, he likely would not have had the opportunity to decline that placement. He has been assessed for safe placement as a result of his communication to DOC but was found not to qualify. The individual's safety	Insufficient Evidence to Substantiate

		concerns have been adequately addressed by his current facility plan, and if new information comes available, the individual can raise those concerns.	
224.	Incarcerated person claims he was targeted by DOC staff, who tried to put the incarcerated person in a cell with a violent individual. When the incarcerated person tried to enter the cell, he was pushed out by the other individual. Then, a DOC staff member used force on the incarcerated person and took him to administrative segregation; he was later issued an infraction for the interaction. The incarcerated person requested monetary compensation, as well as discipline for the DOC staff involved.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO investigated the individual's disciplinary record and staff record of the incident. The individual's infraction was dismissed. The individual took some action within the Resolution Program to address staff misconduct, but that did not reach past Level I. No additional evidence of harm to the incarcerated person was provided to substantiate a staff misconduct claim, and the OCO is not able to compel the DOC to impose staff discipline or monetary compensation.	Insufficient Evidence to Substantiate
225.	Person states that he is being told he still has supervision time when he is released. He is there currently on a community custody revoke, and when he left community custody, he only had 92 days of supervision left. He believes there is an error in the way his time is tolling, and he should be able to release without any supervision.	OCO reviewed his claim and ensured that tolling is the only concern at issue here. Tolling is a community custody issue, which falls outside of OCO jurisdiction; no further action could be taken by the Ombuds.	Lacked Jurisdiction
226.	Person says that they are not being given credit on their Drug Offender Sentencing Alternative (DOSA) revoke for time in compliance.	Person was on community custody during DOSA not in prison facility.	Lacked Jurisdiction
227.	Loved one of an incarcerated individual reports only individuals that have recently recovered from COVID-19 are allowed to go back to work. Loved one also reports DOC staff not wearing their personal protective equipment (PPE) correctly. They request the OCO visit this facility.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO conducted a facility visit and did not observe DOC staff incorrectly wearing PPE. This office explained to the loved one that if she or her incarcerated loved one sees staff not properly wearing PPE, they can alert the shift sergeant and/or file a resolution request with the name(s) of the DOC staff. The OCO's review determined that DOC is not allowing incarcerated individuals who have not recovered from COVID-19 to work as a safety measure to prevent further COVID-19 infection.	No Violation of Policy
228.	Person was transferred because of COVID issues. He was given an FRMT	The OCO was unable to determine a violation of policy. The patient's	No Violation of Policy

	while at new facility and was told he is being transferred because of his medical issues. However, person reports that he does not have any medical issues.	medical need and utilization has resulted in his PULHES "U" code being changed making him no longer eligible for camp. DOC is within policy to transfer the individual.	
229.	Person says that they were denied the opportunity to apply for the Graduated Reentry program because of an infraction. However, recently the law surrounding Graduated Reentry was changed, and the person believes this means they should no longer have to be infraction-free to be eligible for the program.	The OCO reviewed the relevant statute (RCW 9.94.733) as well as the Graduated Reentry Policy (DOC 390.590) and did not find any policy violation in this individual's denial of entry to the program. While the law was recently updated, those changes did not affect eligibility criteria related to infraction history. DOC retains the authority to set criteria for entry into the program, including setting a requirement that an individual remain infraction-free for six months prior to entering the program.	No Violation of Policy
230.	Patient states they came into prison on Medication Assisted Therapy (MAT), patient was taken off the medication.	The OCO reviewed relevant records and the Medication Assisted Therapy (MAT) protocol. It is the facility's protocol to end MAT if the patient's earned release date is more than six months away. He will be referred to treatment in the community if he is released without treatment being initiated again at another facility.	No Violation of Policy
231.	Person says that they were told that their pathway for recovering lost Good Time was not going to be granted because of errors made by their previous counselor. Person says that they have made it one year infraction free and followed all conditions of pathway. Because of DOC's error they lost 40 days of good conduct time.	The OCO reviewed the individual's recovery pathway. No errors or policy violations were apparent. He incurred a serious infraction a few months ago, which caused his pathway to re-start (since one of the requirements was to remain free of serious infractions). He is currently in that pathway and will be eligible for restoration of good time if he completes all of that pathway's requirements (including remaining infraction-free).	No Violation of Policy
232.	Caller states his earned release date passed, and his address was approved and housing voucher obtained. He is now at WCC awaiting release, but that has not happened due to victim notification requirements. Person's notifier was delayed so person believes he could now be held past his PRD, but when he asked staff about it, they told him that victim notification is not the facility's responsibility; it is the responsibility of the Victim Services Provider.	Individual had not exhausted administrative remedies (had not filed a resolution request) on this issue before reaching out to OCO. Further, DOC Policy 390.300 Victim Services requires that an individual's PRD be set for "no less than 35 days" after notification, which is what happened here. Individuals cannot be held after their Max Ex waiting for notification, but this individual is only being held after his ERD, which is not a violation of policy.	No Violation of Policy

233.	This person states they qualify for Track 2 of the GRE program but is denied entry due to being housed in IMU. He has minimum points in maximum setting. His counselor recommended his move out of max custody. He believes this contributed to his denial.	This person does not qualify for GRE because of an enhancement of drugs within a school zone.	No Violation of Policy
234.	Person reports that they signed a document outlining infraction sanctions, but then after they signed, someone at DOC used white-out to change the form to reflect harsher sanctions. He has kited, filed resolution requests and spoken with DOC staff to no resolve.	The OCO reviewed the disciplinary materials and sanctions, and no violation of policy was found. The sanctions were changed on the hearing form after the individual had signed it, but the updated sanctions were mandatory within DOC 460.050 Attachment 2. Because the updated sanctions were within policy, the change on the form constitutes harmless error and is not grounds to overturn the infraction.	No Violation of Policy
235.	Loved one contacted the OCO with concerns about an incarcerated individual's safety and emotional wellness. This person reported that DOC will not give this person underwear and have been withholding meals. He has been kicked and he is bruised from them pushing him to the ground.	The incarcerated individual was released to the community prior to OCO action.	Person Left DOC Custody Prior to OCO Action
236.	Person says that they have asked for their counselor to be replaced on the grounds the counselor is not assisting with his upcoming release and lied about the release date twice. Person says that other staff have helped him to a greater degree. Person reports having mental health issues and this situation is causing a great deal of stress.	Person was released prior to OCO taking action.	Person Left DOC Custody Prior to OCO Action
237.	Person reports that their unit counselor is not answering their kites and kiosk messages and is using other counselors to bring him forms instead of doing it themselves. Person reports the grievance system is also ignoring his grievances. Would like to know the policies surrounding timelines for response from DOC.	Individual left DOC custody shortly after OCO received his concern, and no action was taken by OCO on his behalf.	Person Left DOC Custody Prior to OCO Action
Washington Corrections Center for Women			
238.	Family reports that incarcerated loved one finally had neurology consult and is now awaiting surgery which has been delayed due to	The OCO provided assistance. This office alerted DOC Health Service Manager and confirmed neurology appointment and surgery consult had	Assistance Provided

	COVID outbreaks at the prison. Family also requested information for accessing a therapeutic mattress.	been rescheduled after COVID outbreak delays. The OCO provided family with information for requesting a therapeutic mattress via the CUS or medical.	
239.	Person reports their pod has been under lockdown for several days. Incarcerated people are not allowed to use showers at all. People do not have access to phones. People are housed in dry cells and must urinate/defecate in their own cells in buckets unless they are able to hold it in.	The OCO provided assistance. This office immediately notified the facility of this concern. As a result, incident command was sent to address the conditions of confinement during facility COVID outbreak.	Assistance Provided
240.	Person reported misconduct by a DOC staff member. Person says that they were not treated with dignity and respect and felt threatened. She is in fear of further mistreatment because of her religious beliefs and identity.	The OCO provided assistance. The office alerted the superintendent of the concern and discussed the need for diversity training for staff at the facility. Additionally, the person was moved to another area of the facility.	Assistance Provided
241.	Person says her husband was denied visitation because of an assault between each other from four years ago. Person has been denied for three consecutive years.	The OCO provided assistance. This office raised the concern with headquarters staff. Person then reported to the OCO that she had been told by headquarters that her new application had been approved.	Assistance Provided
242.	Loved one reports patient's cancer treatment is being delayed by DOC institution and medical staff.	The OCO alerted DOC medical and found that following the first consult, oncologist ordered an echocardiogram to occur prior to beginning treatment, which changed the treatment date. The OCO confirmed patient has been scheduled for chemotherapy and post-treatment medication.	DOC Resolved
243.	Person reports cellmate is using racist slurs, threatening, and throwing property. Cellmate makes loud noises by jumping off bunk which aggravates the person’s post-traumatic stress disorder symptoms. She filed three emergency grievances and was offered protective custody.	DOC staff resolved this concern. The person was moved back into her regular campus shortly after filing this complaint.	DOC Resolved
244.	The patient reports that her lower leg and ankle area is swollen, discolored, numb, and hot to the touch. She says this indicates an infection and she has been seen several times by providers, but the treatment is not working. She received an antibiotic; however, she says she did not see any change after	The OCO alerted DOC medical and was able to confirm that the patient was scheduled and received follow up testing to explore additional treatment options and clarify diagnosis. Patient received biopsy and diagnosis was updated; however, patient tested positive for COVID and was moved to	DOC Resolved

	use. Patient was told there is nothing else DOC can offer. She said the affected area has been spreading up her calf. Patient requested follow up testing and diagnosis.	isolation for recovery. Follow up to be assessed post-COVID.	
245.	Person reported PREA incident. Person submitted a request for a "keep separate" order, but was denied by DOC staff.	DOC staff resolved this concern. The person was separated from other incarcerated person by tier.	DOC Resolved
246.	Person was placed in segregation after possible COVID exposure. While in segregation, the person was not able to get their medications.	The OCO immediately notified incident command of this concern. Incident command reported that she had been placed in quarantine status because of possible exposure. Person was able to resume medications the second day.	Information Provided
247.	Person states DOC is responsible for the damage done by detectable illnesses and wants to pursue litigation.	The OCO provided information regarding the tort claim process to the individual and explained that the OCO cannot assist with litigation.	Information Provided
248.	Person has 116 days served time from county jail. She reports that DOC will only apply 88 days.	The OCO spoke with the records department about this concern. Because of the little time that remained on her sentence, the time could not be applied. Person is now at work release.	Information Provided
249.	Person reports incident of staff misconduct occurred while they were being taken to segregation.	The OCO was not able to identify any video, photographs, or other evidence to substantiate the complaint. The OCO did alert the superintendent of the allegation.	Insufficient Evidence to Substantiate
250.	Person reports there was staff misconduct that occurred while person was having a seizure.	The OCO could not identify sufficient evidence to substantiate this concern. No video could be retrieved. The OCO spoke with the superintendent about the incident and addressed the concern of not being able to retrieve video.	Insufficient Evidence to Substantiate
251.	Incarcerated person was infracted for failing to comply with an administrative or post-hearing sanction imposed. Incarcerated person cited policy violations during the hearing process, stating that the DOC did not conduct the hearing within five days of the hearing notice being served, and did not reduce the serious infraction to a lesser infraction as instructed by a DOC Policy Memo from May, 2021.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed the individual's disciplinary hearing materials. The incarcerated person is correct that the DOC did not follow the timelines laid out in DOC Policy 460.000, requiring that a hearing be held no later than 5 days after a notice is received by the individual (unless a continuance is issued). However, Washington Administrative Code 137-28-400 states that "failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding."	No Violation of Policy

		Thus, the DOC is not in a position to overturn the infraction based on failure to follow timelines. Additionally, the DOC Memo issued on 5/12/21 states that serious infractions should be reduced to lesser infractions "when applicable," implying that hearing officers still have discretion on when to apply a lesser infraction. In this situation, the incarcerated person had already incurred similar lesser infractions over the past six months, such that the hearing officer was within their discretion to issue a more serious infraction.	
252.	Caller is concerned about good time and suspended sanctions that are impacting her release time. Originally, she had a sanction that was suspended, but then it was invoked because of a subsequent hearing. The individual believed that sanctions could only be re-invoked for new behavior, and the subsequent infraction had already occurred.	OCO notified DOC facility administrators of this concern, who declined to overturn the later infraction or reduce the time loss. When the hearing officer initially suspended the sanctioned time loss, they did so without knowing any of the details about the subsequent infraction. When they adjudicated the subsequent infraction, they were within their discretion under DOC 460.050 to impose the suspended sanctioned time loss. The sanction imposed was within sanction guidelines.	No Violation of Policy
253.	Person does not understand why they must do substance abuse treatment if it is not court ordered in their judgment and sentence.	The OCO was unable to identify evidence of a violation of policy by DOC. Policy requires person to finish treatment according to their evaluation score.	No Violation of Policy
254.	Person reports they were denied for GRE for a major infraction. She does not see where that applies in current existing GRE policy.	Person was not eligible for criteria to meet GRE as she had an infraction within the past 90 days that disqualified her. Person has been released to community.	Person Left DOC Custody Prior to OCO Action
Washington State Penitentiary			
255.	Incarcerated person reports that, when calling a medical emergency, he was told that he would be infracted for calling a medical emergency unless he was dying. Individual is still sick and worried to reach out to medical.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
256.	Family reports patient has a list of ongoing health concerns that they feel are not being adequately	The OCO alerted DOC healthcare and continued monitoring this resolution post-transfer. The OCO alerted DOC	Assistance Provided

	addressed. Family also submitted paperwork for "Offender Paid Health Plan" but DOC has not followed up.	Facility Medical Director and Health Service Manager of updated concerns and unresolved portions to address at the new facility. The OCO confirmed the patient is receiving appointments and has an active, updated treatment plan including appropriate consults. The FMD also agreed to a call with the patient, family, and OCO to discuss all updates and any pending medical information the family is requesting.	
257.	Family reports the patient has a broken tooth with exposed nerves that cause pain. He has received antibiotics but has not seen a dentist to fix the issue.	The OCO provided assistance. This office notified DOC health services about this concern and requested treatment. The OCO later confirmed that the patient had been seen by dentist. DOC medical also met with the patient at his cell front for a check in and updated pain medication while in quarantine/isolation. Medical provided advice for how to follow up if symptoms return. The patient is on a list for dentist appointments once scheduling is less impacted by the current facility COVID outbreak. The OCO confirmed an active treatment plan. The OCO was able to substantiate general dental delays due to COVID outbreaks and safety restrictions.	Assistance Provided
258.	Family reports delayed dental care for individual following attack and injury.	The OCO provided assistance. This office alerted the Health Service Manager of this concern and requested that patient be seen by dental provider. The OCO later confirmed patient received dental procedure.	Assistance Provided
259.	Person requested explanation of previously closed case; specifically wanted to understand why the DOC's investigation was taking so long following confiscation of their JPAY player many months ago.	The OCO provided assistance. The OCO asked DOC to provide the incarcerated individual with the reason for the delay in the investigation. The incarcerated individual was provided with the reason for the delay as a result.	Assistance Provided
260.	Incarcerated person reports that DOC agreed to add the option to list two disabilities on their DOC issued identification (ID) cards. The individual reports that DOC never followed through with the change and requests that OCO follow up.	The OCO provided assistance. After an inquiry from this office, DOC has now implemented the new protocol for adding two disabilities on incarcerated individuals' DOC issued ID cards. The OCO explained to the individual how to access this new process and update his ID card.	Assistance Provided
261.	The patient reported experiencing chronic pain related to an injury received while in county jail. He recently received an MRI but has not	The OCO provided assistance. The OCO alerted DOC medical and requested follow up treatment. The OCO later confirmed the patient received follow	Assistance Provided

	been provided the results. He declared at least four medical emergencies. Patient reports that he trialed medications, but they were ineffective and caused negative side effects.	up. MRI results did not indicate a need for surgical intervention. Patient was referred to additional providers. DOC also agreed to provide CRC documentation to patient.	
262.	Incarcerated individual reports that he is having trouble getting a release address approved and is concerned that he will not release on his earned release date (ERD).	The OCO provided assistance. The OCO staff spoke with multiple DOC staff to ensure that release planning work was being completed in a timely manner. The OCO ensured that a release plan was approved. The individual was able to release just slightly past his Earned Release Date (ERD).	Assistance Provided
263.	Loved one of an incarcerated individual reports that she was not heard from her incarcerated loved one since the COVID-19 restrictions began. She is worried about him and if he is safe.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO called the loved one and reporter of this concern and she explained that she had spoken to him and he is safe. DOC staff members provided the incarcerated individual with phone access prior to OCO outreach.	DOC Resolved
264.	Incarcerated individual recently discontinued their security threat group (STG/gang) affiliation. DOC is now sending them to close custody at Washington State Penitentiary (WSP) where active STG members are housed. The individual fears they will be harmed in these units due to their status with the STG.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirms that DOC became aware of this safety concern and created a new housing plan for this individual to be managed at a different level of custody. The individual will be transferred to another facility soon.	DOC Resolved
265.	The patient reports denturist took dentures to modify due to bite. He filed a grievance after not receiving them back. The grievance response was that HQ cancelled the contract with the denturist, so things remain undecided. In the meantime, he is having trouble eating and needs assistance.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO alerted DOC medical, substantiated delayed dental care due to COVID outbreak status and dental protocols. Patient was scheduled to receive dentures prior to OCO outreach.	DOC Resolved
266.	Incarcerated individual states they have been in segregation for 58 days and no one has told them anything or when they are getting out.	Incarcerated individual has transferred facilities.	DOC Resolved
267.	The patient reports not getting proper eye examination and needs eyeglass prescription for vision.	The OCO alerted DOC medical and confirmed patient scheduled with laser eye specialist prior to OCO outreach.	DOC Resolved
268.	The patient has not received appointment with cancer specialist after recent diagnosis/test results showing lung cancer.	The OCO alerted DOC medical of concerns, and patient was scheduled for multiple upcoming cancer care appointments prior to OCO outreach.	DOC Resolved

269.	The patient reports his pain medication was changed but later was told it had expired. He was told staff would call about it, but he has not heard anything since and has only received Tylenol for continued pain. He had been told by his specialist not to take Tylenol or Ibuprofen. He also has an active lawsuit involving a provider and is afraid he was reassigned as his provider.	The OCO alerted DOC Health Service Manager, confirmed provider with conflict of interest no longer assigned to patient, and new provider assigned. There is an active treatment plan including renewal of one expired medication until healing progresses. OCO also provided patient with self-advocacy information.	Information Provided
270.	Patient reports that they have had ongoing dental issues and had been told by medical to request a prescription mouthwash order from the dental department.	The OCO provided information to the patient regarding how to request care at the local level to discuss his specific request.	Information Provided
271.	Individual reports that he has evidence from the Washington State Libraries that they sent 93 boxes of donated books and magazines to WSP. He reports that he has not been able to get any confirmation that any of these books have been distributed. He wants to access some of these books.	The OCO contacted the facility and confirmed the books have been distributed.	Information Provided
272.	The incarcerated individual reports that when their Native American tribe sends them funds, DOC takes a portion. The individual reports this is not legal; the tribe is giving them non-deductible funds for COVID relief.	The OCO provided information regarding the deductions matrix. The person requested a copy of DOC Policy 200.000. This office provided two relevant attachments and wrote a letter with this information to the individual.	Information Provided
273.	Incarcerated individual says he filed a grievance in October 2017 after a hearing officer turned off the recorder and threatened him by saying, “if he filed a PREA on his staff he will bury him under the prison.” The alleged comment was in response to the complainant stating that staff violated his privacy when viewing his cell from above in order to find contraband. The staff misconduct grievance was returned as not grievable as the complaint related to PREA. The incarcerated individual wrote another grievance and said the complaint was not about PREA but staff misconduct, as he was threatened. At the time of the hotline call, he was not satisfied with the response from the Resolution Program.	The OCO reviewed all records related to the grievance and infraction hearing, examined the cell in question, and confidentially met with the complainant to better understand the complaint. Based on an independent review of the case, the OCO is unable to find there is evidence to substantiate the complaint.	Insufficient Evidence to Substantiate

274.	Incarcerated person reports that staff have used aggressive language with him when he is experiencing or displaying symptoms of his diagnosed mental health disorder. Person reports that this has been going on for a long time. He would like staff to understand his mental health diagnosis and treat him respectfully and humanely.	The OCO was unable to substantiate all elements of this complaint as evidence does not exist to verify the specific words used during all exchanges between this person and staff. The OCO raised the concern regarding staff aggression with DOC mental health staff to ensure that they are aware of this person's concerns. Additionally, the OCO informed the complainant of related recommendations this office issued in its 2021 Mental Health Access and Services report, including specialized mental health training for custody staff who are assigned to work in residential treatment units.	Insufficient Evidence to Substantiate
275.	Person states they had their JPlayer taken by staff when someone said he had emails he should not have on it. It has now been under investigation for the past three months. He states he cannot go any further in the administrative process and would like his player back. He believes they should have been able to access anything he had by this point.	The OCO contacted the investigation unit to clarify this concern. The JPlayer is still being investigated and a report is expected to be completed within the next few weeks.	No Violation of Policy
276.	Incarcerated individual is calculated as maximum custody and being housed in the Intensive Management Unit (IMU). The individual wants to be able to release from IMU custody and be housed at a lower level of security but DOC headquarters has told him they do not have a safe place for him to be housed in a lower custody level.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO confirmed that DOC does not have a safe placement option for this individual at a lower custody level. DOC shared they are working to open more transfer pod units so that individuals in this situation have more access to time out of their cells while also keeping incarcerated individuals and DOC staff safe.	No Violation of Policy
277.	Patient feels he is being discriminated against for being housed in a mental health unit. The patient states he has to pay $4 co-pay to be seen by a provider for the uncertain possibility of getting over-the-counter (OTC) medications while other non-mental health units can buy it for much cheaper ($1.20) on the store.	The OCO was unable to determine a violation of policy by DOC. DOC 650.040 VI.A states that individuals housed in a residential mental health unit will only have OTC items available by prescription order and these items will be dispensed by the pharmacy.	No Violation of Policy
278.	Individual states his release date has been changed and DOC is holding him past his release date. He states that DOC has denied his address for no reason.	The OCO reviewed the release plan; the address was denied in accordance with DOC 350.200.	No Violation of Policy

279.	Individual reports that security threat groups are a label segregating incarcerated individuals from equal and adequate custody promotions as most of these members are Hispanic and are forced to stay in close custody.	The OCO was unable to substantiate a violation of policy. DOC 470.500 and DOC 300.380 allow DOC headquarters to override the facility custody plan recommendation due to security threat group affiliation or membership.	No Violation of Policy
280.	Incarcerated individual had visitation with his girlfriend terminated due to "constant abuse and belittling." The girlfriend appealed the decision but it was denied due to safety concerns.	The OCO was unable to identify evidence to substantiate a violation of policy. The OCO contacted DOC headquarters staff about the visitation denial and reviewed the reason for the denial. Due to continuous visit violations and criminal behavior, the visitation denial was made in accordance with DOC 450.300.	No Violation of Policy
281.	Incarcerated individual was told that they were going to be transferred to another facility. After they returned from being housed in county jail for court appearances, DOC staff explained that the transfer was not happening anymore. Individual feels retaliated against because the transfer was cancelled.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Prior to the individual's court appearances, the DOC made the decision to transfer this individual to another camp. The individual was in county jail for court for over a month, which prompted DOC to review the original placement when he returned. This new plan and decision changed his placement to Washington State Penitentiary Camp.	No Violation of Policy
282.	Incarcerated individual reports that the resolution program has too short of a timeframe for incarcerated individuals to enter appeals to their resolution requests. The individual reports that five working days is too short to appeal resolutions decisions.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Currently per the DOC Resolution Program Manual individuals have five working days to appeal or rewrite their resolution requests. The OCO understands that there are instances in which this timeframe may be difficult to meet.	No Violation of Policy
283.	Incarcerated individual reports that DOC has calculated his time incorrectly. His attorney has contacted DOC to get it corrected.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed the actions of the DOC records unit and find that they have conducted audits on this time calculation in compliance with current policy. DOC's understanding is that a person does not get credit for time served on another conviction they are convicted of after they have been tried and sentenced for another felony conviction.	No Violation of Policy
284.	The patient reported that DOC had agreed to schedule a neurology specialist consult but patient says he	The OCO alerted the DOC facility medical director of this concern. This office determined that lab work had	No Violation of Policy

	never received the appointment. He has also received documents through a DOC public disclosure request that details potential issue of stage 1 kidney disease discovered during a previous examination by medical staff.	been completed and verified that results showed levels within normal limits. OCO's review also identified two Rubicon neurologist assessments had been completed and a multidisciplinary team found no medical indication for additional testing. The OCO confirmed that follow up with primary provider is planned.	
285.	Incarcerated individual was assaulted by another incarcerated individual. The assault caused serious life-threatening injuries to the assaulted person, and he died in 2021.	This incident occurred before the Unexpected Fatality Review (UFR) process had been implemented. The OCO independently reviewed records related to this incident, including the critical incident review (CIR), security surveillance of the assault, infraction records for the accused, and discussed the investigation on multiple occasions with DOC facility and headquarters leadership. Based on this independent review of the incident, the OCO was able to substantiate that the accused individual did assault the deceased; however, the OCO found that there were no violations of DOC Policy 400.110 Reporting and Reviewing Critical Incidents.	No Violation of Policy
286.	Incarcerated individual reports a lack of access to their family while housed in the Intensive Management Unit (IMU). The individual explains that he has a hard time reaching his family because of when they allow him yard time. He requests access to video visiting with his family and reports he has been housed in IMU for a long time awaiting transfer to another facility.	The OCO was able to substantiate this concern but was not able to achieve a resolution. Currently there is no option for video visiting in WSP IMU. However, facility staff hope to make this available to individuals in the future. The OCO found that the time taken to finalize this person's final housing decision was delayed and that DOC is working to improve their responses and the time it takes to create appropriate housing protocols. This individual will be transferred to an appropriate facility soon.	Substantiated Without Resolution
287.	Incarcerated person reports his cell is too cold and it is causing more health issues.	The OCO was able to substantiate this concern but was not able to achieve a resolution. The OCO contacted WSP staff who explained that DOC is aware of an ongoing issue with the heating equipment in the IMU and staff are working to fix it. The OCO confirmed that everyone in IMU was provided a jacket and extra blanket.	Substantiated Without Resolution

Note: The OCO closed twelve complaints as "Duplicate" in March 2022. A complaint is determined to be a duplicate if there is an existing open case filed by the same complainant regarding the same concern that exists in the OCO case management system.

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

Closed Case Review: These reviews may be conducted by the OCO when a complainant whose case was closed requests a review by the supervisor of the original case handler.

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

IIU or I&I: DOC's Intelligence and Investigations Unit ("Intelligence & Investigations")

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

Pruno: Alcoholic drink typically made by fermenting fruit and other ingredients.

PULHES-DXTR codes: Washington DOC assigns health services codes to every individual incarcerated in its system. These codes, known as PULHES or PULHES-DXTR codes, are meant to note the presence and severity of various health-related factors, such as medication delivery requirements, mobility limitations, developmental disability, and use of mental health services.

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary